Clinical and Fieldwork Placement in the Health Professions

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Second Edition

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Adrian Schoo and Dianne Welch

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Preface

Welcome to the second edition of this book! This book is aimed at students enrolled in a health profession. It is not a discipline-specific book. This second edition places more emphasis on competencies in practice and includes two new chapters—one on reflective practice and one on palliative care. Gaining competencies through clinical fieldwork placement or working in the field is experienced by all health students and is an important part of education for those who are planning to start their career in a health-related area.

In all health professions, there are common competencies as all health professions are concerned with providing best practice to patients or clients. Curran et al. (2011) noted that competency is more than discipline-specific knowledge, skills and attitudes, but also includes understanding the context of the workplace, a person's cognitive and affective resources and provision of a common understanding towards interprofessional collaborations. These common competencies include professional behaviour, ethical behaviour, communication, knowledge of discipline-specific assessment and treatment, lifelong learning and interprofessional practice (collaboration and working in teams). In order to gain these competencies through clinical fieldwork placement, the student is required to spend a certain number of hours in a healthcare setting working within their discipline-specific profession. This requirement is essential to becoming a competent health professional/practitioner and is called various names, such as authentic learning, work-situated learning or work-integrated learning. While you may have thought that, 'This is voluntary, so it is not that important to me, but since I have to pass it to pass the course, I'll have to go through with it!', the clinical fieldwork placement or clinical practicum is where you, as a student, start to understand how theory becomes applied when real, live people require your professional service. It is also the context where professional and ethical behaviours are honed.

Writing a book for all health professions has meant that we, the editors, have made some pragmatic decisions about terminology throughout the book. By using the same terminology throughout, it will be clearer to you what is being referred to, and chapters can be compared using the same terminology. As there are several disciplines represented in this book, the decisions made on terminology were based on the most common terminology used by authors across these disciplines. Here, in the Preface, we want to make it clear what the terminology means.

The term 'fieldwork placement' is used throughout this book as the term that refers to the place where the student is learning about how to apply their competencies in practice through developing and consolidating professional behaviour, knowledge and skills. 'Fieldwork' was chosen as it is broader than 'clinical', as not all placements of all students are always in a hospital or clinical setting. For example, sometimes, the student is placed in

a school or office setting where they work on a particular project. So, 'fieldwork placement' has been used to represent the following: **fieldwork, clinical placement, clinical practicum**, clinical education, fieldwork experience and work-integrated learning settings.

'Fieldwork educator' is the term used for the person who supervises the student in the placement setting. Depending on your profession, this person could also be called your 'preceptor', 'clinical supervisor' or 'clinical educator'. Sometimes this person may also be an academic staff member from the university or educational institution that the student attends, but this is rare. The university staff involved in fieldwork organisation, collaboration or liaison is clearly identified in the text as a university staff member.

Other terms to refer to persons in this book are: 'health professional', 'patients' or 'clients', and 'student'. 'Health professional' refers to any person working in a health area and who has attained a minimum of a bachelor degree in their discipline area. **Patients and clients** are the people the student is assessing, treating, interviewing or working with in other ways. Both terms are used throughout the book as some case studies refer to clinical situations (where 'patient' is used) and other case studies refer to non-clinical situations (where 'client' is used). The student is you. We use the term 'entry level degree' as this encompasses both bachelor degrees and masters entry level degrees.

The term 'work integrated learning' (WIL) is used in this book. This term is still used widely (at the time of writing this second edition) for what we would call 'fieldwork' or 'practicum'. In 2009, the then Australian Learning and Teaching Council completed a large scoping study in thirty-five universities across Australia in relation to this topic from the perspectives of universities and students. The term 'WIL' was defined by them as 'an umbrella term for a range of approaches and strategies that integrate theory with the practice of work within a purposefully designed curriculum' (Patrick et al. 2008: iv, cited in Smith et. al. 2009: 23). In this sense WIL encompasses more than just fieldwork placements per se and is really looking at how these are embedded and integrated within the whole student experience and how we endeavour within the curriculum to integrate the theory with the practice in order to develop a student's competence in practice. We have referred to 'work-integrated learning' in some sections in some chapters when it is appropriate. The term is not always appropriate, and hence we have used 'fieldwork placement' to be more specific and used 'work-integrated learning' when references are to the student learning experience.

There are three parts in the book. Part 1 is Issues for Practice. In this part, information that is important for you to know—regardless of the setting where you will be undertaking your placement—is presented. Topics covered here are: what you need to prepare for placement; your role, rights and responsibilities; models of supervision; assessment; how to get the most out of your fieldwork experience; working in teams; how to positively move on from failure; technology; and reflective practice. Part 2 is Contexts of Practice, and in this part each chapter addresses a specific situated learning experience and guides the student through what to prepare for, what to expect and issues that would be helpful to be aware of during placement. The final part, Part 3, looks at Transition to Practice where the chapters cover aspects of becoming a fieldwork supervisor and how to plan for a student to come back and work in the area. At the end of each part is a checklist for easy reference.

We wish you all the best in your fieldwork placements.

Karen Stagnitti
Adrian Schoo
Dianne Welch

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Part 1

Issues for Practice

With the second edition we have put the broader issues relating to practice in the first part of the book. By doing this you have a broader view of the context in which clinical fieldwork practice sits. In Part 1 we cover issues such as getting ready for placement, your role, rights and responsibilities, supervision, assessment, failing placement, reflective and ethical practice and working in teams.

CHAPTER 1

Getting Ready for Placement

Jane Maidment

LEARNING OUTCOMES

After reading this chapter you should be able to:

- understand the purpose and scope of work-integrated learning
- be aware of the practical steps to take in preparing for the fieldwork placement
- analyse aspects of workplace literacy with reference to oneself and the team
- raise self-awareness about being a student on placement.

KEY TERMS

Emotional intelligence (EI)
Experiential learning
Fieldwork educator
Fieldwork placement
Self-awareness
Self-regulation
Work-integrated learning
Workplace literacy

INTRODUCTION

This chapter outlines a range of factors to consider before embarking on a **fieldwork placement**. These considerations focus mainly on practical matters, and will be relevant to you, regardless of your health-related discipline. **Work-integrated learning (WIL)** has a long and strong tradition in most health-related disciplines. Many seasoned health professionals consider their past student fieldwork placement as the most significant and memorable learning experience in their early careers, which shaped and radically influenced their style of working, future career choices and identification with their chosen discipline. Engaging with real clients in the context of a bona fide workplace brings a critical edge to learning that cannot be captured in the classroom. Together, these factors create an exciting, dynamic

and challenging milieu. In order to make the most of the learning opportunities offered in the field it is important to build a sound foundation from which to begin your fieldwork placement. Understanding the scope and purpose of the fieldwork placement is the logical place to start.

SCOPE AND PURPOSE OF WORK-INTEGRATED LEARNING

The scope of the profession

It may seem self-evident that the purpose of 'going out **on placement**' is to learn how to practise one's discipline. Learning to practise, however, involves more than demonstrating the technical skills associated with your discipline, such as conducting an intake assessment, constructing a splint or charting a patient's medication. It entails:

- discovering and articulating the connections between the theory you have learnt in the classroom and the client situations you encounter on fieldwork placement
- developing greater awareness and analysis of your own professional values *in situ*, where challenging ethical dilemmas can arise
- learning how interdisciplinary teamwork operates, and about ways in which you and people from your discipline might contribute to the team in order to better serve the client population.

As such, the specific competencies you are likely to develop on placement include interdisciplinary teamwork skills, ethical decision-making skills and enhanced communication skills as well as learning various forms of client and agency documentation.

The scope of work-integrated learning is broad, and is influenced by the cultural norms of the workplace, and complex in terms of incorporating a range of stakeholders.

Much has been written about this type of **experiential learning**, leading to a plethora of terminology to describe the activities associated with work-integrated learning. Stints of structured learning in the field have been variously described as clinical rounds, placement, field education and the practicum. Similarly, the roles of those people primarily responsible for facilitating the learning of students in the field are referred to as 'preceptors' in nursing, 'field educators' in social work, 'fieldwork supervisors' in occupational therapy and 'clinical supervisors' in other disciplines. While the names for the fieldwork placement and the names given to your principal supervisor differ from discipline to discipline, the functions of the fieldwork placement and the key people in the process remain the same: to provide a milieu in which you can engage in authentic work-integrated learning, with structured professional guidance and supervision. In this context, the term **'fieldwork placement'** is used for placement or practicum, and **'fieldwork educator'** is used for the person who directly supervises you when you are at the placement.

There are a diverse range of agency settings in which you may be placed, including large hospital settings, community health and non-government organisations. The client group you work with will be determined by the setting of your fieldwork placement, and

might include, but will not be limited to, older persons, mothers with babies, people with mental health issues or those attending rehabilitation. Throughout your degree program you will have opportunities to learn about and experience work in a variety of settings.

The duration of a fieldwork placement can vary, and may include individual days in an agency, blocks of several weeks in full-time or part-time work, or year-long internships. Student fieldwork placement opportunities usually increase in length and intensity over the course of a degree program, with many prescribing regulations for the numbers of days and hours that must be completed. These guidelines are set down by professional accreditation bodies such as the Australian Association of Social Work, the Australian Nursing and Midwifery Council, the World Federation of Occupational Therapy and the World Confederation of Physical Therapists. In Chapter 11 you will be able to read more about the significant role of professional associations in providing governance and regulation influencing health education and practice.

THINK AND LINK

You are gaining the knowledge and learning the skills to become a member of your profession. Chapters 2 and 11 discuss your role and responsibilities and how professional associations, universities and government work together to enable you to take part in fieldwork education.

While you may have entered the program with the goal of working in a specific field such as disability or mental health, it is important to be open to the professional opportunities that can be generated in all settings. Frequently after having been on placement, students become passionate about working in fields they had not previously thought about. It is important not to hold tight to preconceived ideas about a specific place or client group you want to work with until you have finished your degree. If you are placed in an agency that differs from your preferred choice (which happens frequently), demonstrating annoyance or lack of interest will have a negative impact upon your engagement with the staff and clients in that agency. This standpoint can also lead to you becoming less open to exciting alternative learning and career possibilities.

Wherever you go on placement, paying attention to planning and organising is the key to successful completion. Research on problems experienced by students on fieldwork placement identifies common stressors that can be addressed with some forward planning. These include issues such as financial constraints, managing child care, travel arrangements and attending to personal safety (Maidment 2003).

GETTING READY

Planning for the placement begins well before your actual start date. Table 1.1 lists a series of factors to consider, and strategies that past students have utilised.

Table 1.1: Planning and organising for placement

Pre-placement planning and organisation	
Finances	Being out on placement incurs additional costs. Start budgeting early for travel to and from your placement, purchase of work-appropriate clothing, any required equipment or books, additional child care expenses, accommodation and depleted wages if you need to cut back on paid work hours. Some students apply for bank loans to cover extra costs during this time.
Program administration	All programs organising fieldwork placements require you to complete a set of paperwork beforehand. Ensure that you submit this material to the field coordinator by the dates required and that you attend any information sessions offered by the institution.
Police checks	Most institutions require students to produce a **police check** at the time of interview or on the start date. These can take several weeks to process. Make an application for a police check well in advance of beginning your placement. A police check must be completed for each current year of your course.
Working with children check	Most states now also require students to provide a **working with children check** before placement with minors. These checks also take some time to process, so begin the process at least two months before your placement begins.
Child care	Students with children frequently need to find additional child care while on placement. Discuss this need well in advance with your family members, local child care centre and other potential minders. You may need to use after-school care or employ a caregiver in your home.
Travel	Think about how you will get to your placement, whether by car, car pooling, public transport or bike. Plan your route from home to the placement agency if you are travelling to an unfamiliar location, and allow for extra time on the first day.
Dress code	Find out if there is a prescribed agency dress code or uniform you are expected to wear on placement. Standard of dress in an agency setting is likely to be more formal than the casual clothes you would wear to university.
Placement interviews	Some fieldwork placement programs require students to attend an interview before beginning. Prepare a curriculum vitae to take with you. Ensure you also take your driver's licence, police check and working with children check. Before attending an interview make sure you know the location of the agency, and familiarise yourself with the work of the agency on the Internet or by requesting information to be sent by post. Have some ideas about what you are wanting to learn during the placement, and prepare some questions to ask at the interview. If you do not need to have an interview, but are simply given a start date, make contact with your fieldwork educator over the telephone to introduce yourself before you begin. Be informed about the purpose of the agency and the scope of the work before you start.

Table 1.2 outlines matters you need to familiarise yourself with during your first week on placement.

Table 1.2: First week: Planning and organisation

Agency administration	During the first week on placement students frequently need to complete agency confidentiality contracts, provide personal ID to collect and sign for keys or building security cards, be supplied with a computer password or security code, learn the systems for car and room bookings, and become informed about office procedure for recording your whereabouts during the day.
Safety	Most agencies have policies and procedures to address personal and occupational safety in the workplace. Ask to read these and discuss safety processes associated with office appointments and home visits with your fieldwork educator during the first week.
Orientation	It is usual to have an orientation phase to the physical surroundings and the work of the agency, and to meet your new colleagues. By the end of the first few days in the agency you should know where you can leave your personal belongings, use desk space and who to approach when you have questions or issues to address. Ask what people normally do at lunchtime and how long you have for this break. As the placement progresses you will continue with your orientation to the field of practice and organisational policy, and learn agency information recording and storage procedures.
First client contact	It is usual at the beginning of a placement to spend some time observing your supervisor or other practitioners working with clients. In order to prepare for this observation it is helpful to have read the client file and spoken with the fieldwork educator about particular points to look out for during your observation. Debriefing with the fieldwork educator after these client sessions is the time to ask questions, and discuss ideas. Having observed a number of sessions, you may then often work with an experienced practitioner. Students in their final years of training can be expected to work relatively independently with clients, while continuing to receive professional supervision.

Once you arrive at the agency to begin your fieldwork placement, it is important from the outset to demonstrate your workplace literacy.

WORKPLACE LITERACY

Traditionally, the term **workplace literacy** has been adopted to describe 'the written and spoken language, math [maths] and thinking skills that workers and trainees use to perform job tasks or training' (Askov et al. 1989, cited in O'Conner 1993: 196). In this discussion the notion of workplace literacy is broadened, and defined as being the sets of skills, attitudes and behaviours required to practise competently in the field. This definition incorporates the spectrum of attributes that have been written about extensively under the umbrella

term of **'emotional intelligence' (EI)**, including demonstrating **self-awareness**, **self-regulation**, self-motivation, social awareness and social skills (Cherniss 2000: 434). It is now recognised that bringing these particular attributes to practice when working within teams and with clients can enhance service delivery outcomes in healthcare settings (Meyer et al. 2004).

Specific competencies that relate to demonstration of emotional intelligence include the capacity to negotiate and mediate as well as deal with conflict in a constructive manner. These competencies include demonstration of complex verbal skills and thoughtful awareness of the impact of non-verbal behaviour.

THINK AND LINK

Reflecting on your attributes is part of reflective practice and becoming a competent practitioner. Chapter 3 takes students through a process of how to develop being a reflective practitioner.

REFLECTION

DISCUSSING EMOTIONAL INTELLIGENCE

Complete this reflection before you go out on placement. Listed below are sets of attributes associated with self-awareness, self-regulation, self-motivation, social awareness and social skills. Identify the specific attributes you are confident you can demonstrate while you are on placement, and those you feel you need to develop. Discuss your self-assessment with a partner or group members. When doing this exercise, be mindful of the feedback you have already received from your peers, friends, family and lecturers about the way you communicate, behave and work with others.

During the early meetings you have with your fieldwork educator, it may be helpful to share the list of attributes below, and discuss your strengths and weaknesses in these areas.

Attributes of emotional intelligence

Self-awareness

- Being aware of own bias, assumptions, and prejudices
- Setting appropriate professional boundaries
- Having self-respect
- Striking the balance between working independently and interdependently when required.

Self-regulation

- Demonstrating skills in time management
- Applying conflict management strategies when needed
- Exercising impulse control
- Managing stressful situations and strong emotions without becoming overwhelmed
- Being free from emotional dependence.

Self-motivation

- Initiating your own learning and practice responses in the workplace
- Being positively responsive to feedback
- Being proactive in addressing injustice at micro, meso and macro levels.

Social awareness

- Recognising the social norms of the workplace setting and responding appropriately to them
- Demonstrating personal temperament conducive to working in an agency and teamwork setting
- Applying moral courage and demonstrating social responsibility.

Social skills

- Showing respect, and responding with empathy
- Demonstrating a genuine interest in the lives of others
- Understanding and using a range of nonverbal behaviours to put clients and colleagues at ease.

Source: Beddoe & Maidment 2009: 27–8. Reprinted with permission, Cengage Learning Australia

REFLECTION

Clinical reasoning includes using all the skills and knowledge you have to help you interpret a client's situation and the course of action (or not) you should take. Reflect on which skills you think would be involved in clinical reasoning.

Emotional intelligence

Clearly, factors associated with EI include aspects of behaviour that are quite personal and sometimes difficult to discuss, but have significant bearing on how student performance is assessed. Simple things like being on time for work and meetings, being open to constructive feedback, attending to personal hygiene, having sound communication skills and respecting established lines of authority are all part of demonstrating workplace literacy. Familiarising yourself with the guidelines and attendant expectations set out by your educational institution and placement agency will enable you to 'know the rules' and requirements for successful completion of your placement. However, in most workplaces there are some unwritten rules. As a student your role during the early days on placement is to become aware of these unwritten rules. Use your supervision time to discuss your observations in private before commenting in a team meeting or the tearoom about what you see. In this way you respect the established workplace culture and give yourself the time and opportunity to become informed. At first, however, remain silently curious.

It can be challenging negotiating your student role at the beginning of fieldwork placement in an unfamiliar context, while you are also feeling the pressures of being

assessed and needing to demonstrate competence. These conditions frequently result in students feeling stressed during the first placement (Zupiria Gorostidi et al. 2007).

MANAGING THOUGHTS AND FEELINGS

Going out on placement can be exciting, scary and challenging, all at the same time. Often you are juggling multiple responsibilities with working in paid employment, continuing sporting commitments, providing child care as well as being on placement. It is important therefore to give some thought and preparation to how you might manage the levels of stress that students commonly associate with this experience. Past studies in this field (Maidment 2003; Zupiria Gorostidi et al. 2007; Moscaritolo 2009) suggest using the following techniques to manage stress:

- taking care of the practical arrangements such as organising travel, child care and other work commitments before fieldwork placement
- framing the placement as a *time to learn* rather than viewing the experience as primarily a time to demonstrate proficiency and competence
- being prepared and organised to meet workplace commitments and deadlines (using a diary to record meetings and assignment commitments)
- focusing on developing supportive collegial relationships with other team members in the agency, including developing peer instruction and mentoring relationships
- using problem-solving techniques such as consultation, sourcing new information, prioritising and asking for help
- giving time to maintaining personal interests (such as sport and hobbies) and friendships outside of the placement
- learning relaxation techniques, including breathing and meditation exercises, looking for ways to appropriately increase humour in the workplace and at home.

Proper self-management of thoughts and feelings in the workplace relates to demonstrating professional behaviour competencies in the realm of emotional intelligence. These competencies relate to having realistic expectations of yourself and others, being socially aware of team and individual dynamics, communicating with sensitivity, and cultivating strong teamwork skills by making constructive professional contributions to client care.

CASE STUDY

Grier's situation

Read the following case study and identify strategies you might use if you found yourself in Grier's situation.

Grier, 21 years old, has just started out in her first fieldwork placement in a community health centre. She has been looking forward to having some hands-on experience with real clients, but is also feeling nervous. She has read all of the materials about what she is supposed to do on placement, and has been told that the agency is a very busy place. However, she had not quite realised how busy everyone would be, and now feels she

is in the way. At the team meetings where client situations are discussed, each team member gives a brief summary of who she or he has seen and provides a progress report. These contributions are snappy and to the point. Everyone seems very organised and efficient, confident and outspoken. The staff talk about how 'stretched' they are and how they do not have enough time or resources to do everything required. Grier is feeling nervous about taking up people's time, not making a useful contribution and being in the way, and is worried about eventually needing to speak up in the team meeting.

QUESTIONS

1 What other words could you use to describe Grier's emotional state?

2 Refer back to the emotional intelligence list. What emotional intelligence attributes do you think Grier should call upon?

3 What action should Grier take to feel more at ease in the setting?

SUMMARY

This chapter outlines the factors to consider when getting ready for your fieldwork placement, while identifying key features for working with others and managing well during the fieldwork placement. Planning, organisation and time management are key skills that will contribute to success in the field, along with having effective interpersonal skills such as those identified under workplace literacy. These interpersonal skills contribute to professional behaviour competencies. Being on placement is frequently a time of considerable personal and professional challenge and change.

In closing I am reminded of an observation made by a professor of engineering some years ago, when he observed that students returned from field placement 'six months older but two years wiser'.

Discussion questions

1 Note how you feel about going out on your first placement. Identify what you think might be your major challenges. Think about ways you might address these challenges.

2 Being organised is critical to successfully completing your placement. Identify strategies you might use both on placement and at home to ensure you have effective time management systems during fieldwork.

3 On placement you are likely to encounter clients from diverse backgrounds. What strategies do you think you could use to communicate effectively with people who are quite different from yourself?

4 When you first start working in the field it is sometimes hard to stop thinking about client situations when you go home. How do you think you might manage this issue?

Portfolio development exercise: Problem solving

This exercise is designed to be completed for your portfolio several weeks prior to going out on placement.

Take a sheet of paper and, down the left-hand side of the page, list all of the real and potential problems you may encounter while doing your placement. These issues might entail practical considerations such as arranging and paying for additional child care, or emotional needs such as not feeling particularly confident. On the other side of the sheet list all of the resources you have access to that could help address the potential problem areas. These resources might be located within your family and friendship network, such as people you can ask for help; personal strengths you can apply, such as determination and organisational skills; or external resources such as scouting around local op shops to buy some 'professional' clothing to wear on placement. Try to be creative and lateral in the way you think about overcoming potential obstacles to achieving success on your placement. Once you have completed these lists identify three key areas you will address before starting placement, and write a plan including action steps for what you will do to address these areas. Remember to include timeframes for when each step will be completed. The key to a successful placement is being prepared and organised.

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CHAPTER 2

The Three Rs: Roles, Rights and Responsibilities

Linda Wilson

LEARNING OUTCOMES

After reading this chapter you should be able to:

- identify key fieldwork stakeholders in successful industry placements
- understand a general overview of key fieldwork stakeholder roles, rights and associated responsibilities (three Rs)
- discuss the shifting boundaries between university, student and fieldwork placement agency, depending on the context.

KEY TERMS

Fieldwork
Fieldwork placement agency
Stakeholder
Three Rs (roles, rights and responsibilities)
Work-integrated learning

INTRODUCTION

This chapter aims to introduce you to the notion of the **three Rs (roles, rights and responsibilities)** for each stakeholder within a **work-integrated learning** experience. This information clarifies the three Rs, which may in turn assist in the successful completion of your placement. If needed, it may provide you with the wherewithal to address any inequities or other problems that might arise, allowing you to complete a course **fieldwork** requirement within an industry placement.

A very important and exciting phenomenon throughout universities is the increasing emphasis on fieldwork placement as a core component of entry-level courses. This increases the need for all stakeholders to understand the specific fieldwork placement

requirements. For example, in some faculties, there are course rules stating that a fieldwork failure can be a reason to exclude a student from the course. This highlights how fieldwork, in some courses, can be treated differently from other core **units** (you may be allowed to fail another core unit twice before you can be excluded). This is why you need to have a greater understanding of the three Rs (roles, rights and responsibilities) as they pertain to fieldwork. Without this knowledge, a situation could arise where you are disadvantaged.

In the health and behavioural sciences disciplines there are considerable variations in fieldwork placement form and format. For example, fieldwork:

- can occur at different levels of courses; for example, expectations for fieldwork placement at first year are very different from those required in a final year placement
- occurs in a variety of settings that have differing expectations
- has specific requirements imposed by some professions; for instance, dictating which health professionals can supervise a student while on placement.

Many of these elements are profession specific, and lead into the university requirements for the fieldwork placement. Hence the approach in this chapter is a generic one, and you as a student should ensure that you have information specific to your course and discipline area.

KEY STAKEHOLDERS

There are three key **stakeholders** in the fieldwork process. They are the *student*, the **university** (represented by the fieldwork organiser or academic supervisor) and the *placement agency* (represented by the fieldwork educator or supervisor).

Broadly, the university is the placement instigator and has the major component of the organisational role and responsibilities. Students in some settings may contribute to the identification of fieldwork placement agencies, but primarily their role and responsibilities centre on engaging actively in learning, while the agency is the learning environment facilitator.

Even though a successful fieldwork is a partnership, each stakeholder has his or her own areas of interest, which at times can be in conflict with the interests of other stakeholders and the work-integrated learning objectives.

Table 2.1 provides examples of stakeholder interests as either primary or secondary. The interests under each heading (primary and secondary) are not prioritised, as these will vary between individuals and groups. A primary interest for the **fieldwork placement agency** is its core business; for the university its prime interest is placement organisation and students successfully completing placement. For most students the bottom line is passing. Some may scoff at this, and profess altruistic values, which is fine, but the reality is that a fieldwork placement experience can at one end be a successful learning partnership and at the other a massive conflict. Understanding what is important to other stakeholders aids clarity, and is a step to establishing a respectful working partnership. So it is best to be clear from the start what the bottom line is for all stakeholders. If this information is not provided to you, you should ask the university representative.

Table 2.1: Examples of stakeholders' interests

Interest examples	Stakeholders		
	Student	**University**	**Placement agency**
Primary	• Passing the fieldwork	• Successful placement organisation • Academic rigour	• Service provision (core business) • Staff and service users
Secondary	• Positive learning experience	• Outcomes of the placement that are of benefit to the agency	• Student's learning experience

THINK AND LINK

In Chapter 11, stakeholders are considered from a professional, government, university, health and human services and student perspective. This chapter and Chapter 11 reveal the complexity of practice that occurs when fieldwork placements are involved.

REFLECTION

A MINUTE FOR PRIORITIES

As a student, it might be useful to take a minute to think about what are your priorities regarding your next fieldwork placement.

1 Identify what is the most important issue (bottom line) for you regarding your fieldwork.
2 What are your secondary interests concerning your fieldwork placement? For example, 'It would be nice if …'

ROLES, RIGHTS AND RESPONSIBILITIES

As we clarify the key stakeholders' defined roles, embedded in each discussion are the rights and responsibilities of each stakeholder. The fieldwork placement relationship between each stakeholder is based on the recognition of mutual rights and responsibilities. This also includes the responsibilities to other parties outside the immediate fieldwork placement partnership.

The specifics of each stakeholder's responsibilities to other parties will vary depending on the initial situation. The following are some examples:

› students may have work or family responsibilities
› the university will have responsibilities to others; for example, external professional registration bodies as well as other students. The university also has responsibilities to the rest of the university, ensuring academic rigour and the university's reputation

› the fieldwork placement agency's responsibilities are related to its core business; for example, service users and staff members. Agencies need to take several steps (for example, police checks) to protect their staff and service users. Agency responsibilities to clients also raise important issues for students regarding confidentiality and privacy.

The university should be a conduit for students to ensure that if they are not provided with the information before placement they know where to access it in the agency.

The key agency person (fieldwork educator) regarding the fieldwork placement is the one who takes on the direct supervision of the student. The fieldwork educator in each agency may also be the key contact person for you and university staff. Universities rely heavily on the fieldwork educators, and value their contribution to your education. Ensuring that you have a good learning experience is a partnership between the agency, you and the university. All of these and many other elements contribute to a complex relationship within a fieldwork placement.

Table 2.2 has a summary of the three Rs and the three stakeholders.

Table 2.2: Outline of stakeholder three Rs

Three Rs	Stakeholders		
	University	**Agency**	**Students**
Role	• Placement parameter identifier and organiser	• Facilitator of student learning	• Active learners
Responsibility	• Ensure an appropriate agency is organised • Ensure academic rigour • Provide clear information regarding placement parameters • Ensure safety of students	• Orientate and induct student to agency • Provide learning opportunities • Provide feedback to the student and university regarding student performance	• Inform themselves of the placement parameters and the agency requirements • Self-manage their own learning while on fieldwork placement • Use initiative in learning • Seek and utilise feedback on placement performance • Treat the fieldwork placement as if it were employment • Observe university statutes, regulations and policies, and behave accordingly as a representative of the university
Rights		• Protect core business	• Ensure an appropriate, stimulating learning experience

Role of the university through its representatives

The role of the university can often be broken into several elements. They include:

- *identification of work-integrated learning parameters* including:
  - fieldwork objectives
  - requirements (hours)
  - set and mark assessment and evaluation requirements
- *organisation of fieldwork*: for example, identifying appropriate agencies and liaising with them and the student, as well as initiating necessary screening processes; for example, police checks or working with children checks
- *delivering administration requirements*: for example, ensuring course and university requirements
- *monitoring and supporting*: after having placed the student, the university's responsibilities continue through monitoring student progress and development, with a view to offering guidance or advice to assist the student and fieldwork educator in professional development.

PARAMETERS

Fieldwork parameters are what the placement must function within. They can take two forms: those imposed by the university and those originating from the field.

University parameters

Before a fieldwork placement even begins, university fieldwork parameters (such as the hours, objectives and assessment requirements, and whether it is a core course requirement) have gone through many stages in an approval process inside (accreditation processes) and outside (external registration bodies) the university. These processes contribute to ensuring the academic substance of work-integrated learning.

The aims and objectives will vary between fieldwork placements, with some being observational only and others involving considerable interaction on your part. It is essential that all parties, particularly you, are very clear about the aims of the fieldwork placement aims. For example, if you are purely observing, and the placement agency expects you to be interactive and contribute to the environment, this could be the source of considerable angst.

After parameter development the university is then responsible for the communication (to other stakeholders) and the meeting of these parameters.

Field-based parameters

Many fieldwork placements in the health and behavioural science field will provide services to individuals who are considered vulnerable clients (refer to the Part 1 checklist for a list of service users identified as vulnerable). In order to ensure client safety, a pre-placement police check (criminal history) of students is required, where the relevant police department prepares an official historical report that covers all criminal information specific to an individual. The report is an official document that has several issues associated with it.

- In some organisations the criminal history report requirement is policy based, and in others it is enshrined in legislation. An example of a policy-based requirement is that of the Department of Health in Victoria, which has incorporated its requirements in policy guidelines. A legislative example is the *Working with Children (WWC) Act 2005*, which requires all who volunteer or anyone who works with children to undergo a mandatory screening process. Funded organisations have the responsibility to ensure that employees or volunteers obtain a *Working with Children Check (WWCC)*, if required. For more information on the WWCC or the WWC Act 2005, and the subsequent review and amendment bill that became operational in 2010, visit the Department of Justice website at www.justice.vic.gov.au/workingwithchildren.
- Such legislative and policy requirements mean that agencies (particularly government-funded) *will not* consider allowing students into the agency until they have seen a criminal history report. This creates the situation where all students enrolled in most health courses are required to have a police check if undertaking fieldwork placements. If you have any concerns regarding your criminal history, you are strongly advised to discuss these with the university at the earliest opportunity.
- There are two types of police checks, national and state. The process of gaining a **police record check** is state specific. If students are required to have a check from overseas, try the Australian Federal Police website at www.afp.gov.au/what-we-do/police-checks/national-police-checks.aspx. The university will usually have processes in place to facilitate applications for a police check, and will have information for students on how to go about this.

In relation to a criminal history report, the police department has very strict guidelines concerning the release of criminal history information to individuals and organisations outside the particular police departments. The general requirements for a police check are as follows:

- a specific form is available from the relevant police website (state-specific or federal)
- unless otherwise arranged, costs are met by the applicant (you); to access the student rate for the report you must have a personalised form that the university signs
- a new report is required every 12 months. This may mean that a student enrolled in a three-year undergraduate course that has fieldwork each year may need to apply for three reports.

It is inappropriate for universities to be making final judgments about the appropriateness of students' criminal histories for a particular agency. While the student is on placement, the agency has the responsibility for the student, as well as its core business. As such, the agency will need to make the final decision regarding the appropriateness of the report content for the agency.

Another issue surrounding the criminal history report is its *ownership*. To *own a report*, students should have the report sent to them personally, because if the report is sent to the university it is not allowed to give the student or anyone else a copy. The university should know what is in the report and sight it, but the agency will make the final decision.

In the event that an agency deems the report inappropriate, universities may attempt to find an alternative fieldwork placement. But there are many difficulties with this, as most funded agencies require an appropriate police check, which is why if you have any concerns

regarding your criminal history you need to discuss them with the university as soon as possible.

THINK AND LINK

Having a criminal history can make undertaking fieldwork placement extremely difficult. Other legal issues are discussed in the Appendix.

Assessment and evaluation

Assessment and evaluation requirements are the critical endpoint for both the student and university. From a student's perspective, this is often the most important information. The university needs to ensure the dissemination to all stakeholders of clear assessment information before the placement. Aside from the actual tasks that must be done while on fieldwork placement, several other issues need clarification before placement. These issues include:

- Who does the responsibility for the final grade rest with? Is it the university or the agency?
- What are the assessment tasks, and what is the placement performance evaluation?
- In making judgments, does the university seek the advice of fieldwork educators who have close contact with students during the fieldwork experience, or is the evaluation based on observations during visits?
- What is the process for dealing with the final assessment grade?

The importance of the assessment and fieldwork placement evaluation for students necessitates that considerable time is spent clarifying these issues, which is primarily a university responsibility.

THINK AND LINK

If you are interested in passing your fieldwork placement, you need to know the type of assessment used to evaluate whether you are successful or not. Chapter 6 is dedicated to assessment issues on fieldwork placement. Refer to this chapter if you want more information on assessment during fieldwork.

PLACEMENT ORGANISATION—PARTNERSHIP DEVELOPMENT

There are many organisational elements for which the university has total responsibility, including the identification of appropriate agencies, and preparing students and the agency for fieldwork placement. The responsibility for the organisation of the fieldwork placement and setting the tone regarding how the fieldwork placement proceeds rests with the university. Some placement organisations may require student input; for example, if a student is undertaking the fieldwork placement as a distance unit.

A successful fieldwork is an outcome of a partnership between the key stakeholders. The characteristics of a partnership include:

› mutual cooperation
› clear responsibility
› the achievement of a specified outcome.

Mutual cooperation is an essential element of many aspects surrounding fieldwork. For example, when organising a placement agency a university is bound by what is an appropriate and available venue. Sometimes this may conflict with a proximity issue for students. The solution is mutual cooperation.

Each stakeholder brings their individual perspectives on the issues, but in order for a placement to be successful the starting point should be common information between all the stakeholders.

REFLECTION

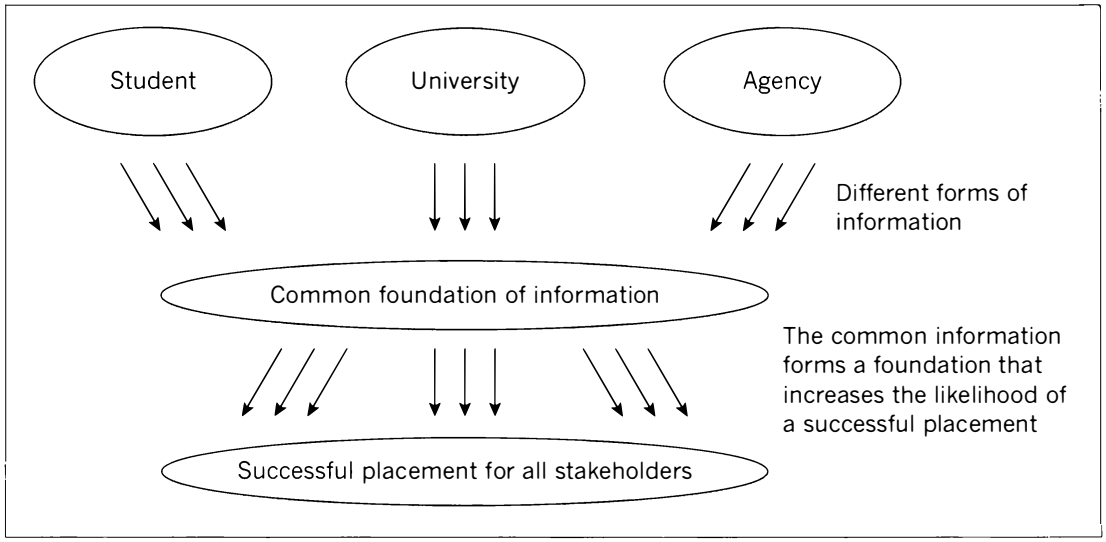
DO I HAVE TO TRAVEL?

When you receive information about your placement from the university, have there been times when the placement meant you had to travel? Did you try to negotiate a different placement closer to home? If there were no suitable placements closer to home, what did you do? Was compromise a part of the solution?

Common information

Common information includes anything pertaining to the placement that, if disseminated, fosters transparency and accountability. This sharing of information needs to be orchestrated by the university. As outlined in Figure 2.1, an absolute necessity regarding a successful fieldwork placement is that fieldwork information is common to all stakeholders.

Figure 2.1: Common foundation for information between stakeholders



Each stakeholder contributes to the common information, which includes but is not exclusive to:

- the student:
  - any information that could impede placement completion; for example, a back injury
- the university:
  - general aim of the course
  - course structure information
  - how the fieldwork placement relates to the rest of the course
  - aim of the fieldwork placement: observational or participatory
  - fieldwork organisation process
  - fieldwork assessment and evaluation requirements
- the fieldwork placement agency:
  - agency constraints
  - agency values
  - core business
  - organisation protocols for the placement.

The sharing of information should be done in an accessible manner that can be referred to as the need arises; for example, the university-prepared information should be provided to the agency and students, either in a hard copy in the form of a manual or contract, or using an accessible electronic mechanism. The dissemination of information to all stakeholders enables a clear starting point and eliminates surprises. It also creates an awareness of the other stakeholders' needs with a view to ensuring a successful placement for all stakeholders.

CASE STUDY

What information is missing in the following situation?

THE SITUATION

A week into a full-time six-week fieldwork, a placement agency has called the university wanting to discontinue a placement because Maree, a first-year student, is not meeting agency expectations. Maree is not initiating any actions and cannot undertake the tasks the agency needs her to do. The university rings Maree to organise a meeting. Maree is very distressed, and bursts into tears, saying that no one has explained anything (she didn't find the toilet until the second day), and it is not clear what tasks should be done and how. The language used is foreign and everyone in the agency is cliquey, and she does not know who to get information from.

QUESTIONS

1 What information from each stakeholder is missing in this situation?

2 The university

3 The fieldwork placement agency

4 The student

Insurance

The university has an occupational health and safety responsibility to students regarding their safety and welfare. Most universities have insurance that covers public liability and professional indemnity, as well as personal accident insurance cover, for students not covered by WorkCover. Universities often have this information available on their websites. The policy usually provides insurance cover for compensation to a third party in respect of physical injury and/or property damage caused by a student. This includes the student as well as others. The university should provide the student and agency with a certificate of currency, as well as explain the process for putting in a claim.

Confidentiality and privacy

The nature of service provision, and the collection and storage of intimate information in the health and behavioural science field, mean that **confidentiality** and privacy are major considerations.

As with other aspects of fieldwork placement, each stakeholder has specific responsibilities. The university has a responsibility to develop in students an awareness of the issues surrounding confidentiality and privacy. The agency has a responsibility to inform students of its policies. You have a responsibility to ensure you are informed about and adhere to agency policies.

In general terms, someone who is bound by the rules of confidentiality must not pass onto anyone else information concerning individuals, unless:

- the individual consents or agrees, or
- it's the only way a job can be completed properly. For example, a health worker can pass on information about individuals without getting permission first if it is necessary to ensure an individual receiving services (patient, client, service user) will have access to the best treatment needed; or the law says there is an exception to the general rule. The exceptions usually permit the release of confidential information without an individual's consent if it is in the public interest.

Students and the university need to take all reasonable and necessary steps to maintain confidentiality, and protect and advance the reputation of the agency and its clients.

THINK AND LINK

Confidentiality is an important issue when working in health and human services. The Appendix has further information on confidentiality from a legal perspective and Chapter 12 discusses ethical practice.

Payment of students

Before fieldwork placement finalisation, the issue of payment for tasks performed by you during hours on fieldwork placement needs to be clarified. Where you and the agency enter into agreement for you to be employed on a casual or part-time basis, such agreement must operate outside the student fieldwork placement, and should not operate to the detriment

of your or the agency's performance of the fieldwork placement. You do not get paid for undertaking fieldwork.

Placement costs

Sometimes within agencies there are established protocols regarding such things as parking, meals and refreshments. The university needs to clarify meeting these costs before fieldwork placement commences. It is usual that you will either pay the going rate or make other arrangements for yourself. Universities are not usually liable for these types of costs.

General control and discipline

Students and staff of a university, although within a fieldwork placement, are bound by the rules, regulations, protocols, procedures and by-laws of the agency. Discipline and control of students and staff of a university is a university responsibility. The person in charge of the agency or department is entitled to issue instructions to university students and staff on matters affecting client–patient–service user care, and such instructions should be complied with fully and promptly. Students are also bound by university rules regarding their behaviour while on fieldwork placement, and should ensure they are aware of what is expected of them while on placement.

REFLECTION

ANOTHER FILE!

As a student in your final year placement, you have been placed in a small understaffed community organisation. The first 20 hours of the placement have been spent filing and photocopying. What do you do?

Role and responsibilities of the placement agency as represented by the fieldwork educator

The agency and fieldwork educator play a vital role in your fieldwork placement and professional preparation as they provide you with relevant field-based practical guidance, stimulation, encouragement and advice, as well as constructive criticism.

There are many issues surrounding placement organisation and associated individual responsibilities that need to be clear at the outset. For example, you need to have the name of the contact person for all correspondence from the university, and whether it is the fieldwork educator's responsibility to complete the relevant assessment and evaluation requirements. Also contact processes with the university need to be established in case there are any concerns about your progress or competence.

Areas in which the fieldwork educator can assist the student are:

- creating an environment where the student feels at ease and is a participant rather than observer
- treating the student as a professional colleague

- orientating the student to the organisation (for example, explaining the day-to-day issues, such as parking), and inducting the student to the agency through providing information on procedures and discussing agency philosophy, policies and occupational health and safety issues
- discussing student expectations, and any written university requirements for the student during the placement
- demonstrating various instructional techniques and discussing methods and materials relevant to particular service users
- providing opportunities for the student to observe and become familiar with as many aspects of the agency as possible
- providing the student with continuous comprehensive and constructive performance critiques, identifying specific strengths, weaknesses and strategies for improving the student's competence
- providing continuing liaison and consultation with the university coordinator of student placements
- discussing agency expectations
- completing the relevant evaluations and assessments of the student in conjunction with the student.

Role of the student

The role of the student while undertaking a fieldwork placement is that of an active learner. The agency is responsible for facilitating the learning, and the university is responsible for its organisation. You are responsible for your own learning.

While undertaking a fieldwork placement, you are accepted by courtesy of the agency and staff, and are expected to conduct yourself in a professional manner, accepting responsibility in your role as a student. The activities undertaken while on fieldwork placement will vary depending on the type of agency and the placement parameters. An important point for you to note is that many fieldwork placements are organised without payment to the agency.

Even though your role is unpaid, it is preparation for future workplaces, and therefore associated workplace behaviour is expected from you. These behaviours are professional behaviour competencies that you are developing through your placement experience. They include the following:

- Punctual and regular attendance at the placement venue.
- If you have an unplanned absence during the fieldwork placement, it is expected that you will notify the agency as early as possible and negotiate with their fieldwork educator as to how this lost time will be made up. If the agency does not know when you are coming, it makes it difficult to plan, which could have a negative impact on the opportunities afforded to you. You will also need to identify a communication strategy with the agency; for example, an exchange of contact details between you and the agency's fieldwork educator.
- It is also your responsibility to notify the fieldwork educator of any circumstances likely to pose a risk to either you or any of the agency's clients or staff; for instance, the presence of any infection or an inability to perform a certain task, such as lifting.

- Identification of appropriate attire should be done pre-placement. Individual requirements vary according to the agency, the task and settings. A dress code would be based on industry standards; for example, if you are working with children, then appropriate attire might be neat casual, yet if you were working in the head office of an organisation, business attire would be more appropriate. In some environments there may be certain safety concerns requiring specific attire. Some settings require students to wear uniforms. You should identify the dress requirements before commencing the fieldwork placement.
- While on fieldwork placement you are expected to locate and familiarise yourself with local policies and procedures relevant to your role within the agency.
- You must negotiate with the fieldwork educator, client or client advocate acceptable access to confidential client records in order to complete placement tasks. You must follow agency protocols and maintain confidentiality at all times.
- You must communicate with agency staff and/or the fieldwork educator any incidents or issues that may be significant to the wellbeing of clients, patients or service users.
- Injury on fieldwork placement or an accident must be reported to the immediate fieldwork educators, and appropriate action taken within the organisation. You are also expected to notify the university as soon as possible, and lodge a report with the university.
- You should communicate with the university regarding any issues that may be significant regarding the fieldwork placement.
- During the placement, you are expected to initiate discussions regarding your placement performance with the fieldwork educator, identifying strengths and areas to focus on for improvement. This can be done in a formalised review at specified times or in an ad hoc manner. Often a good fieldwork educator will initiate these conversations, but it is your responsibility to obtain feedback.
- It is also your responsibility to ensure you and the fieldwork educator complete the required evaluation and assessment requirements.

Before undertaking fieldwork placements, you will need discipline-specific information, but there are some general issues that are relevant across professions. Aside from the course-related information, other areas of information and skill development you need include:

- processes to clarify personal values: there are often situations that will challenge your values
- clarification of what you are responsible for and to whom you are accountable
- time management
- professional issues, including:
  - duty of care
  - occupational health and safety: self
  - occupational health and safety: others
  - occupational health and safety: environment; for example:
    - infection control
    - lifting
    - emergency situations

- communication issues: written or verbal communication with:
  - professionals and other team members
  - service users, patients and clients
  - the university
- privacy and confidentiality: your responsibility is to ensure you are informed about the issues and adhere to the policies; further information regarding the legislative requirements can be found at www.privacy.vic.gov.au.

THINK AND LINK

Reflective practice will help you cope with your responsibilities. Chapters 3 and 5 provide some practical exercises to help you reflect about how you perform. Chapter 1 also discusses professional behaviours in regard to emotional intelligence. Go back to Chapter 1 to refresh your memory on what these behaviours are.

ADDRESSING PLACEMENT CONCERNS

Sometimes concerns arise regarding a fieldwork placement for one of the stakeholders. There are mechanisms in place that are enshrined in the rights and responsibilities afforded to each stakeholder. These mechanisms are context specific, and will vary between placement agencies as well as from university to university. Both agencies and universities have mechanisms to address concerns.

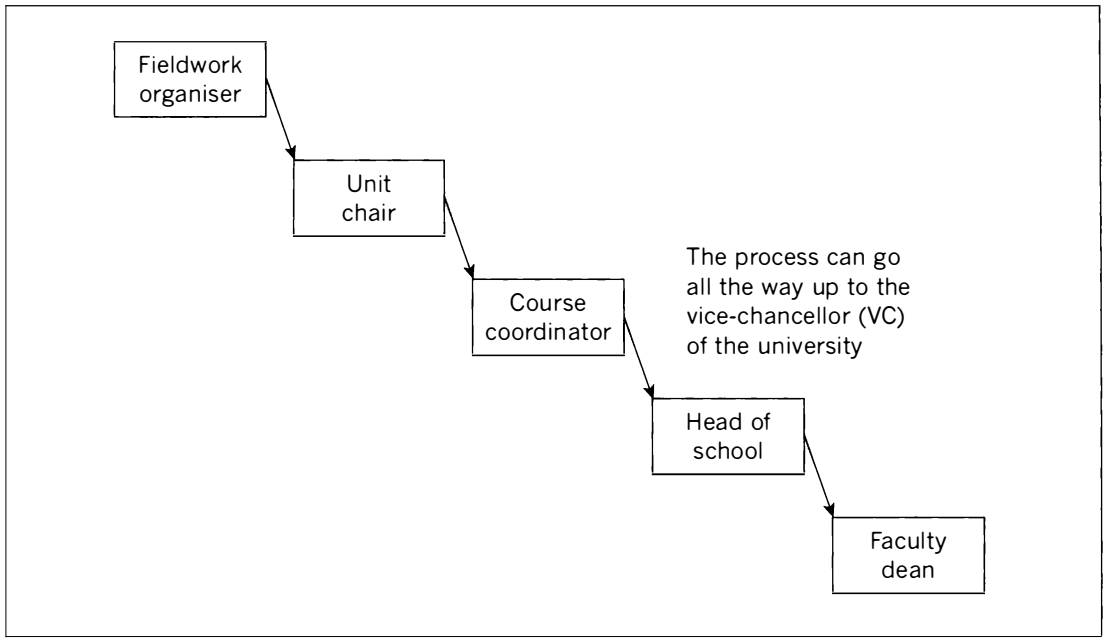
Student concerns

From your perspective, problems can arise concerning placement from two perspectives. The first is in relation to university actions and the second is events at the agency. The processes to deal with both of these perspectives are hierarchical and evidence based. You may need an external party to assist in either process. A useful resource is the local student union.

If you have concerns regarding the actions of a university's representative, the steps to go through are outlined in Figure 2.2. At any point you can approach any level of the university hierarchy with your concerns. For example, if the concerns are with the fieldwork organiser or academic supervisor, it would be appropriate to approach the unit chair. If the issue is not resolved to your satisfaction, you could approach the course coordinator or the head of school.

Concerns regarding an issue or event at an agency require a different process. It is the university's responsibility to monitor and support fieldwork placements, and you should contact your university fieldwork organiser or academic supervisor. This person will talk you through your options and help you to identify strategies to deal with the scenario as appropriate. Also within the agency there should be specific complaint protocols. These processes are all evidence-based. You should ensure that you are familiar with the agency policies. You can discuss these with the university academic supervisor, who can support you through the process as appropriate.

Figure 2.2: University mechanisms to address student concerns



Agency concerns

To address agency concerns regarding a student while on placement, there need to be clear communication processes identified between the agency, student and university. It is presumed that the agency will, where possible, attempt to address any concerns directly with the student. If advice provided does not bring the desired result, or where serious concerns exist about the student's competence, it would then become a university responsibility. The agency has the right to deny the student access to the agency, thus ending the student's fieldwork placement. This can occur if the student's actions or behaviours are inconsistent with the agency's expectations. For example, the student may not be performing patient- or client-based actions competently; the agency's primary responsibility is to its clients or patients, and on that basis could deny the student access to the agency. The university needs to have clearly outlined processes in place to deal with such issues.

The university has the responsibility to ensure that there are support mechanisms in place for the agency and for you. Sometimes students can be intimidated by what is occurring and may find it difficult to initiate any action, but as with other stakeholders, students have rights as well as responsibilities. To access your rights, you may need to speak to a party outside the placement: an appropriate choice would be a student union representative. They have knowledge of university processes, and would focus on your best interests, as student advocacy is generally part of their role.

CASE STUDY

Three scenarios

SCENARIO A

You are working with people who frequently exhibit aggressive behaviour. You are unsure of the best way to handle the situations as they arise. You ask your fieldwork educator, and she says, 'Don't worry, you will soon pick it up.'

1 What do you do?
2 Who should you consult?

SCENARIO B

You have been asked to undertake a risky complex task that you have only seen described in your textbook. Your fieldwork educator is being called away by an emergency. She asks, 'Will you be all right if left alone?'

1 What do you say?
2 Who is principally responsible for the outcomes in this situation?

SCENARIO C

In your role as a student you have witnessed the mistreatment of clients, patients or service users. An experienced staff member with whom you are working continues to verbally abuse clients, stating that this is the only language that they understand. This staff member will have input into your evaluation.

1 What do you do?
2 What information do you need?
3 With whom should you discuss the issue?

SUMMARY

A successful fieldwork placement results from a partnership where all stakeholders are clear regarding the three Rs (roles, rights and responsibilities). This, in conjunction with discipline-specific information, forms the core information that must be communicated between the three key stakeholders.

As with all partnerships, if one stakeholder fails to meet its responsibilities, this could have a negative impact on the rights of other stakeholders. If this occurs, the processes to address this imbalance should be outlined, and accessible to all parties, at the beginning of the fieldwork.

From a student perspective, awareness of your role, rights and responsibilities is a foundation for a successful fieldwork placement.

Discussion questions

1 What are the key elements to facilitate a successful fieldwork placement?
2 As a student, what are your responsibilities regarding your fieldwork placement?
3 How do you address problems in your fieldwork placement?

Portfolio development exercise: To prepare for your fieldwork education

This exercise is designed to be completed for your portfolio once you have been allocated an agency but prior to going out on placement. The information that you collect will come from a range of sources for example the University might give you an agency profile, you could do an internet search and call or visit the agency. You may need other information but this is a minimum.

What information do you have about the agency? For example:

- What is their mission and the underpinning values?
- Who are their primary clientele?
- How many sections in the organisation?

What information do you have specific to your placement at the agency? For example:

- How do you get to the agency?
- What is the dress code?
- What specific section of the organisation are you in during your placement?

Assessment

- List the assessment tasks you are expected to complete while on placement.
- Are there any hurdle requirements?
- Examine what the marking criteria is that you will be evaluated against

Contact details

- Who is your primary contact?
- What contact information are you giving them for you?
- What is the emergency contact for the university?

USEFUL WEBSITES

Australian Federal Police: www.afp.gov.au/what-we-do/police-checks/national-police-checks.aspx

Department of Health: www.dhs.vic.gov.au

Department of Justice: www.justice.vic.gov.au/workingwithchildren

State police:

New South Wales Police: www.police.nsw.gov.au

Queensland Police: www.police.qld.gov.au

South Australia Police: www.sapolice.sa.gov.au

Tasmania Police: www.police.tas.gov.au

Victoria Police: www.police.vic.gov.au

Western Australia: www.police.wa.gov.au; www.checkwwc.wa.gov.au

Privacy: There are some individual sites but the Commonwealth site has links to relevant state laws at www.privacy.gov.au/law/states.

Office of the New South Wales Privacy Commissioner: www.privacy.nsw.gov.au

Office of the Queensland Information Commission: www.oic.qld.gov.au

Office of the Victorian Privacy Commissioner: www.privacy.vic.gov.au

CHAPTER 3

Becoming a Reflective Practitioner

Helen Larkin and Geneviève Pépin

LEARNING OUTCOMES

After reading this chapter you should be able to:

- describe what it means to be a reflective practitioner
- explain why reflective practice is important
- identify and apply models of reflective practice
- be able to recognise a reflective approach in your writing and in your practice
- apply reflective practice to a range of scenarios.

KEY TERMS

Critical reflection
Mindfulness
Reflective and reflexive practice
Teaching and learning

INTRODUCTION

> 'Where is the Life we have lost in living? Where is the wisdom we have lost in knowledge? Where is the knowledge we have lost in information?' (T. S. Eliot, 'The Rock', 1934)

In today's society, the availability of information is seemingly unending. However, it is what we do, and why we do what we do with this information, that is critical. As a student, you may feel overwhelmed by the volume of information presented and the knowledge and skills you are required to develop. You may become frustrated when you ask questions of teaching staff or fieldwork educators, but don't get definitive answers. There are not always clear solutions to the complex array of clinical situations that you will be faced with as a student and into the future as a health professional. Moving from information to knowledge to wisdom requires a lifelong reflective approach to practice. However, what does this mean and how do you do it? This chapter explores the area of *reflective practice* and why it is

important, and provides some helpful tips on how you can develop a reflective approach, not just as a student, but as a lifetime practitioner. This will help you develop your own competencies in critical thinking and reflection on theory and practice and should help to bridge a gap that you may perceive between the two.

WHAT IS REFLECTIVE PRACTICE?

Terminology in this area can be confusing, and multiple terms are often used in the literature including: 'reflective practice'; '**critical reflection**'; 'reflective thinking'; 'reflective learning'; 'metacognitive reflection'; and '**mindfulness**' (Rogers 2001). Some of the earliest concepts of reflective practice were proposed through the work of Donald Schön (1995) who recognised the need for an approach that assisted practitioners to respond to situations that were ill-structured and/or unpredictable. He also proposed that reflection could be the way to bridge the gap between theory and practice (Taylor 2010). The work of others in this area, including but not limited to, Mezirow (1981), Boyd and Fales (1983), Street (1991) and Moon (2004), is also well recognised.

REFLECTION

Find and read two publications by significant authors to start building your own knowledge and understanding of reflective practice. Write a paragraph or two that describes the key characteristics and an explanation of why reflective practice is important to you.

Epstein (1999) argues that exemplary practitioners have the capacity for critical reflection that 'pervades all aspects of practice' (p. 833). It can be seen as the distinguishing feature between a technician and a professional and helps to make the link between theory and practice. In the context of medical practice, Epstein has promoted reflection as a way of examining 'belief systems and values, deal with strong feelings, make difficult decisions and resolve interpersonal conflict' (p. 833). Reflection is about being aware of what we are doing as professionals, being aware of the broad contexts in which we work and how these influence our actions and the actions of others. This awareness or reflection can assist in identifying routines and habits, critiquing their purpose, relevance and effectiveness from different perspectives, and change our practice in response (Taylor 2010).

In trying to define reflective practice, Moon (2004) argues that at its simplest there is a common-sense version of reflection to which we can all relate, that is, the thinking and problem solving that we do in our everyday lives without necessarily labelling it as being 'reflective'. Look at the reflective exercise below.

REFLECTION

You need to buy a 21st birthday present for a good friend. How do you go about deciding what to buy? What is the process by which you decide on the present?

In your response you could have asked yourself a number of questions such as: what are their interests, likes and dislikes; do you want a present that will last; what do they already have; how much do you have to spend; are you buying a group present; can they return it if they don't like it? You may seek opinions or advice from others and refine your potential purchase along the way. This is an example of a common-sense type of reflection described by Moon (2004) that happens routinely and habitually, often at a subconscious level. Like all human characteristics, some people are naturally reflective in their everyday life while others find this more difficult.

When it comes to an academic or professional context, reflection is often seen as more difficult and less tangible. It can be difficult for some people to identify what constitutes reflection in a professional role. While the definitions of reflective practice vary and the terms used may be confusing, there is some consensus on what characterises a reflective approach. Nolan and Sim (2011: 123) summarise it as being able to:

> Identify one's own values, beliefs and assumptions, consider other perspectives or alternative ways of viewing the world: being able to identify what perspectives are missing from one's account; identify how one's own views can have a particular bias that privileges one view over another; perceive contradictions and inconsistencies in one's own account of events; and imagine other possibilities.

The outcomes of a reflective approach are a transformation in some way of perspective, thinking or action. In health professions, reflective practice has been applied to teaching and learning activities, fieldwork supervision and practice development, and has expanded beyond the boundaries of health to business, management and leadership, and environment and sustainability (Taylor 2010).

WHY IS REFLECTIVE PRACTICE IMPORTANT?

As a student, you have access to vast amounts of information to inform your practice, not all of it authoritative or useful. With knowledge in the health field advancing at a rapid and exponential rate, much of what we know today will become obsolete in a few years' time; to a certain degree you are being prepared for a future that is unknown to you and to your teachers (Boud & Falchikov 2006; Kek & Huijser 2011). Simply knowing facts and information is no longer sufficient in this rapidly changing world.

Academic staff are, therefore, trying to prepare you for jobs that either don't yet exist, consist of many unknown variables, or will be influenced by a variety of internal and external factors. Therefore, it is not appropriate to focus on learning by rote a vast array of facts and figures and applying them in a formulaic manner. Although you may be confident of your ability to multitask and access a wide range of information on any particular topic or issue, your ability to critically evaluate this information does not necessarily follow (Kek & Huijser 2011). You need to be able to sift through the available information, select information that is authoritative, critically reflect on it, apply it to your personal and work related contexts, and then evaluate the outcomes. In a rapidly evolving and increasingly complex health environment, highly developed technical skills need to be integrated with reflective and clinical reasoning. Plack and Santasier (2004) argue that reflection is the

hallmark of professional practice and while some people are naturally reflective, others have more difficulty. However, reflective thinking can be learnt (Kek & Huijser 2011). So if you are one of those students who struggle to 'reflect', don't despair.

So, why reflect? Reflection on previous experiences will increase your understanding of what happened and why it happened and, as a result, will inform your future decisions and experiences. The analysis associated with the process of reflection contributes to enhancing your practice. It will make complex problem solving easier, will expand and consolidate your knowledge base, and make you a more competent and complete health professional (Ghaye & Lillyman 2011).

What does it mean to be reflective?

One of the difficulties for students who are not naturally inclined to be reflective is understanding what this means. Have you ever had the situation where you have been asked to write a reflective journal while on fieldwork placement and you don't know what to say? Or, the person marking your journal comments that what you have written is not a 'reflection'. The work by Kember et al. (2008) in defining levels of reflective writing, may help you to understand what the characteristics of a reflective approach are, particularly when you need to provide evidence of this in the form of a written journal or similar. Kember et al. argue that there are four levels of reflection. These include:

1. habitual action/non-reflection
2. understanding
3. reflection
4. critical reflection.

Habitual action/non-reflection

Many students find it difficult to get beyond the first level of *non-reflection*. At this level, students often describe in great detail the circumstances that occurred in relation to a particular fieldwork or other experience. The description is just that, descriptive and concrete by nature and lacks any evidence of deeper thinking. This is indicative of a surface approach to learning and may be characterised by 'rigidly following the steps of procedures they have been taught. No thought is given to applicability or alternatives' (Kember et al. 2008: 373). Look at the following journal entry extract. Is this similar to something you have written in the past?

> Today I saw a man with bipolar disorder. He was in a manic phase and his symptoms were quite acute. It was difficult to have an actual conversation with him because he could not focus on what I said, on the here and now. It was the first time I had seen a person with such severe symptoms and it was difficult to gather information. I decided to talk to the other staff members who had seen him before to get a better understanding of who he is, what he likes and what circumstances led to him being admitted to hospital.

Understanding

At the level of *understanding* there is evidence that you have searched for a deeper meaning of the concepts but have provided no evidence of applying them in practice or relating them

to your own personal and academic experiences (Kember et al. 2008). Compare the next journal entry extract with the previous one.

> After the session with my client, I wrote my progress notes and realised that I did not get as much information as I could have. It felt like we did not go into enough depth. I think I probably asked too many questions and did not let my client think for himself. I am not comfortable with silence so I just asked more questions instead of giving him time to process the question and respond in his own words.

Reflection

At the third level, that of actual *reflection* you are able to apply knowledge and information to real-life circumstances and relate this to your own experiences. You are able to demonstrate 'personal insights that go beyond book theory' (Kember et al. 2008: 374).

> I realise that I didn't do as good a job of interviewing the man as I would have liked. I realise now that I actually felt uncomfortable in this situation. I have no experience of people with such acute mental health symptoms and I wanted the interview to be over as soon as possible so that I could get out of that room. I should have used the motivational interviewing strategies we have practiced in class. Some of these strategies would have helped me with structure and direction during the interview. I felt anxious and nervous and I let these feelings get the better of me and I didn't act as professionally as I could have.

Critical reflection

Finally, critical reflection occurs when you demonstrate how your thinking and perspective has changed as a result of your reflection, that is, there is a 'transformation of perspective' (Kember et al. 2008: 374). Particularly important here is that critical reflection requires you to bring often ingrained assumptions and values from the subconscious to a conscious level of thinking. The resolution of these assumptions may result in a time of uncertainty or discomfort but results in a changed view, that is, a transformation.

> After my last attempt at doing an initial assessment, I know that in the future I need to change the way I go about it. First of all I need to put aside my prejudices that I think perhaps I have had towards people with mental health conditions even though I was not aware that I had any and I am shocked to think this is the case. I have done a lot more reading about bipolar disorder and understand the symptoms better. I also know that I can get a bit anxious before challenging situations so I will minimise this by being well prepared and more comfortable with silence. I have practised some simple relaxation techniques that I can use at these times also. I have learnt so much from my first attempt. My experience on this placement has really challenged my personal values but I now have a much better understanding of mental illness and my reactions to it.

When you are able to critically reflect, you then become both **reflective and *reflexive***; that is, you respond to your new insights and understandings and change your responses, attitudes and values.

REFLECTION

Look at a piece of reflective writing you have completed during fieldwork or as part of a university assignment. Analyse it against the levels of reflective practice described above.

Which of the four levels was evident in your writing? Was there a level that stood out particularly? How could you increase your level of reflection?

WHAT CONTRIBUTES TO REFLECTIVE PRACTICE?

You may believe it is the responsibility of academic staff and clinical educators to teach you what it is that you need to know before embarking on your career as a health professional. However, these people are concerned not only with teaching you, but more importantly with your learning. This distinction between **teaching and learning** is where your responsibility as a learner is emphasised. For centuries, students were considered to be 'empty vessels' waiting and ready to soak up the information and knowledge that was presented. Teaching was viewed as the mere transmission of knowledge (Biggs & Tang 2007).

Today we know that learning is not merely the acquisition of skills. It is also about understanding, critiquing and modifying knowledge, new or existing, in light of the contextual factors. This is where information starts to transform into knowledge and knowledge into wisdom. This can only occur if reflective practice is central to learning. The mere memorising of information and the ability to reproduce it is characteristic of a superficial approach to learning (Biggs & Tang 2007) without reflection. In this instance, students will have difficulty applying the information learnt to other circumstances (Moon 2004), and this is not helpful in becoming an effective practitioner in complex and rapidly changing health care environments. In contrast, a deep approach to learning is characterised by developing a greater understanding of the information and the underlying principles and how they relate to previous knowledge and experience, and most importantly questions the arguments that have been presented (Moon 2004: 59). Implicit in this deeper approach to learning is a reflective approach. In adopting and nurturing a deep approach to learning you will be responsible and accountable for your own learning and professional practice. You will also be able to adapt your knowledge and skills to the diverse and evolving contexts in which you will work as a health professional into the future.

THINK AND LINK

Chapter 14 discusses what it is like to work in a diverse setting and Chapter 19 discusses work in a mental health setting. Chapter 13 discusses working in palliative care and uses Gibbs' model (Gibbs 1988) to reflect on practice in such a setting. See these chapters for examples of the type of practice setting where reflective practice will bring a deeper appreciation of your own skills, prejudices and attitudes.

Contributing to a reflective approach is the concept of mindfulness that is becoming increasingly used, particularly in medical and health education. **Mindfulness** as outlined by Epstein (1999) is a logical extension to reflective practice. In order to critically reflect it is important to cast aside biases and prejudices, and become more aware of your own mental

processes. According to Epstein, 'a mindful practitioner attends in a non-judgemental way, to his or her own physical and mental processes during ordinary and everyday tasks to act with clarity and insight' (p. 833). While the importance of evidence-based practice cannot be underestimated, mindfulness recognises also the importance of experience and skills, not always explicitly stated, and that clinical judgment or reasoning is both the art and the science. The person with the health condition is seen not just as a disease but with their own personal reaction to that health condition, a set of personal activities and lifestyle preferences that are important to them, and a variety of personal and contextual factors that influence their participation within their chosen communities. Thus the concept of a mindful practitioner ensures that we are able to critically reflect on the full range of circumstances that a client presents to us, that these are considered by us on the available evidence and other skills and experiences, and that we reflect in a way that is free of prejudice or our own personal values (or at least we are aware of these and their influence on our decision making).

BECOMING A REFLECTIVE PRACTITIONER

This chapter has outlined the characteristics and importance of being a reflective health practitioner and what contributes to such an approach. For some people, being reflective is a natural ability, while others struggle to understand and demonstrate it. However, there are ways to develop reflective skills and build your competence as a reflective practitioner. Here are a few examples of simple actions to facilitate your development in this area.

- Take a proactive approach to your learning. Set learning goals early and be active in planning your placement and your learning opportunities.
- When you are on placement, ask your fieldwork educator to explain their reasoning in relation to the clients that you see.
- Recognise that often there is no single, clear, correct solution to complex clinical issues.
- Don't be fearful about getting something wrong or looking stupid or foolish in front of your peers and others. Put yourself out there and you will generally be rewarded for having a go.
- Manage your personal expectations so that you aren't fearful of doing or saying the wrong thing. If you are so focused on achieving at a high level, this can make you reluctant to take risks and overly concerned about making a mistake.
- Go and search for information, and don't expect it to come to you.
- Expect to learn things about yourself that you may not like or that will make you feel uncomfortable.
- Focus more on the process (that is, what is actually happening) so that outcomes/results are not at the expense of processes that reflect the complexity of many clinical situations.

THINK AND LINK

Read the information contained in Chapter 5 that outlines how you can take a more pro-active approach to your learning outcomes when you undertake clinical placements. The model described there will help you to reflect on your learning and assist you in developing learning goals.

There is no magic formula or recipe for becoming more reflective. It is a personalised experience where the processes are often unseen or internalised. However, the outcomes of a reflective approach are more obvious. If you are not reflective in your approach as a health practitioner you may make hasty decisions to complex problems, leading to poor outcomes for your clients. This can also cause you to feel frustrated and dissatisfied. Understanding that there is not necessarily a clear solution to complex problems will help relieve you of the pressure to always be 'the expert' and feeling that you have to come up with the solution for the clients with whom you work. Being reflective will assist you to help clients and colleagues to develop solutions that work for them individually and are more sustainable into the future. By seeing reflective practice as part of **lifelong learning**, your role as an effective health practitioner will be sustained and strengthened well into the future.

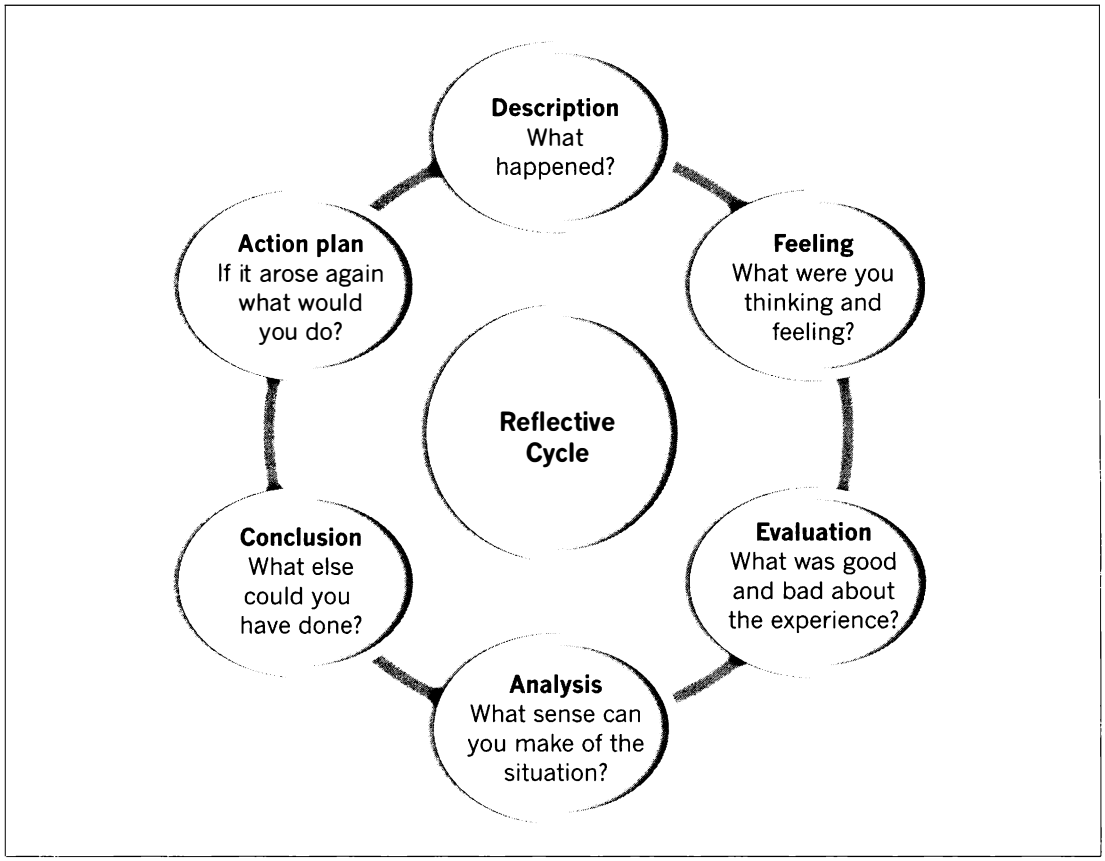
While it is true that there is no clear recipe for becoming more reflective, different resources and models have been developed to guide the development of a reflective approach. Some are discipline based (reflective practice for nursing, reflective practice for occupational therapists, reflective practice for social workers, etc.). Others are broader and not limited to one discipline but designed to guide practice in certain areas of health. In this chapter, we present two different and broader models of reflection, by Gibbs (1988) and Atkins and Murphy (1994).

Gibbs' model of reflection (1988) is based on an iterative approach (refer to Figure 3.1) and comprises six steps that constitute a reflective cycle. First, the reflection begins with an account of the experience. The practitioner describes what happened. Closely linked with this first step is the second one where the feelings and thoughts associated with the experience are explored and identified. This factual and emotional description is then evaluated in step 3. There needs to be a reflection about what was positive and potentially negative about the experience or, in other words, what were the strengths and limits, what went well and what did not go well. The fourth step consists of an analysis of what happened. The practitioner is asked to try and make sense of the experience or event, to identify reasons or justifications to explain what happened in order to move to the fifth step and create new and informed approaches to the experience. Gibbs was mindful of ensuring that actions would be integrated in reflection in order to modify and enhance practice. This is where reflective practice becomes reflexive. Therefore, in the last step, the action plan, practitioners integrate new knowledge, behaviours and skills learnt from the experience and approach a similar experience in the future from a different perspective.

This model can be useful when analysing a non-routine, critical or challenging incident, during or after which you felt perhaps unsettled or mentally or emotionally drained or wanted to know more (Kember et al. 2008). An alternative approach is proposed by Atkins and Murphy (1994) who have focused their work on identifying cognitive and affective skills that are necessary to be a reflective practitioner. They have identified and defined the following five skills of a reflective practitioner (Spalding 2012: 88):

- Be self-aware: be aware of, recognise and acknowledge your own feelings.
- Be descriptive: make sure you provide a detailed and precise account of the event, of the situation.

Figure 3.1: Gibbs' model of reflection (1988)



Source: Gibbs 1988: 46

- Critically analyse: conduct an examination of all angles/elements of the situation and what may have contributed to it (knowledge, assumptions, alternatives, etc.).
- Synthesise ideas: search for and identify relevant new knowledge, incorporate new and old knowledge to reach new perspectives of the situation.
- Evaluate: does the new appraisal make sense, is it relevant, is this new perspective/alternative 'right' for this person in this context.

These two models described above are designed to assist you in developing a more reflective approach. As discussed previously, people vary in their ability to be naturally reflective. Some students exhibit a high level of critical reflection while some practitioners of some years' experience continue to have difficulty in this area. The pathway from novice to expert and the entry point at which you start to improve your reflective thinking is not clearly marked and is not related to years of experience. The tools provided here are offered as one means of making more tangible the way in which you can develop your skills in an area that is sometimes viewed as somewhat abstract and subjective.

SUMMARY

Being a reflective practitioner is an essential attribute of an effective healthcare practitioner in a rapidly changing healthcare environment. For some, such an approach will be naturally intuitive, while for others it will be less tangible, more elusive and difficult to understand. However, reflective practice is something that can be learnt, improved and developed. This chapter has explored the nature of reflective practice and presented some models that will explicitly assist you to develop the characteristics of a reflective practitioner. Reflective practice is a characteristic of a deep approach to lifelong learning and ensures that your professional skills and knowledge remain relevant long into the future.

Discussion questions

1 Now that you have read this chapter, what does reflective practice mean to you? What does it mean to your clients and your professional practice? Discuss your views with colleagues from other disciplines. What are the differences and similarities?

2 Think back about a particularly challenging or puzzling situation in your fieldwork, personal or professional experience, and ask yourself if you have you been reflective. When and how have you been a reflective practitioner? What aspect(s) of reflection have you applied? Which one(s) are you most comfortable with? Why do you think this is?

Portfolio development exercise: Creating a reflective piece

This portfolio development exercise has been created to help you to:

- exercise critical thinking and judgment in developing new understanding
- demonstrate application of knowledge and skills with responsibility and accountability for your own learning and practice
- adapt your knowledge and skills to diverse contexts of decision making
- demonstrate theoretical knowledge and reflect critically on theory and professional practice.

1 Reflective writing

Kember and colleagues (2008) defined four levels of reflective writing. Using an example (case study) from your in-class or fieldwork education, apply the four levels of reflection to this example or experience and create a reflective piece. Use each of the different levels to help you understand the differences between each level and work through the increased reflection and complexity of these levels. Remember that the four levels of reflective writing are:

- habitual action/non-reflection
- understanding

- reflection
- critical reflection.

2 Gibbs' model of reflection

Read the following case study and start to think about it in relation to Gibbs' (1998) model of reflection.

You work in an aged care facility in a large urban setting. The residents are all over the age of 65 years and come from diverse cultural backgrounds. You received a referral for Mrs Spychalski who had a stroke five months ago. Mrs Spychalski is Polish and arrived in Australia when she was 28 years old. As a result of her stroke she has constructional apraxia and you have been asked to assess the functional implications of this.

You know that one aspect of assessing constructional apraxia will be to ask Mrs Spychalski to copy two-dimensional geometric forms and also replicate three-dimensional structures using blocks. After reading her chart and talking with other members of the team, you find out that Mrs Spychalski is a very proud woman who raised seven children and worked three jobs for several years while her husband was away working for the railway company. Her English is limited and it is hard for her to express herself. She is struggling to adapt to her changed life in the residential facility and is frustrated with the changes in her abilities and the limitations she now faces of which she is very aware.

With this knowledge, you meet Mrs Spychalski early in the afternoon in the lounge room. The room is bright and spacious. You introduce yourself to Mrs Spychalski and explain that you have been asked to do an assessment of the difficulties she is having and that to carry out the assessment you will ask her to complete some tasks. You explain that some tasks may seem simple and others may be harder. You ask her to try her best. You tell her that the results of the assessment will help in developing an intervention plan that will, hopefully, help her do the things that are important to her.

You place the blocks on the table next to Mrs Spychalski. When she sees them, at first she seems surprised then gets agitated. You repeat the explanation you gave her and try to reassure her. No matter how much you try to explain the purpose of the test and why you are using blocks, Mrs Spychalski becomes more and more agitated. She starts crying, speaks in rapid Polish, is clearly upset and throws the blocks off the table. Other staff members walking by hear the screams and come to find out what is going on. You explain the situation, apologise, and the staff, understanding the situation, take Mrs Spychalski back to her room and suggest you discuss what happened with the team and try to find another way to assess her level of function.

Using the information contained in the case study above, apply the six steps of Gibbs' model of reflection (as shown in Figure 3.1 earlier in the chapter) to this situation to: increase your understanding of what happened; gain a different perspective of the situation; and apply this new understanding and perspective in an alternative approach that would facilitate a more positive outcome.

- What can you say about each step?
- What have you learnt from this reflective exercise?

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CHAPTER 4

Models of Supervision

Ronnie Egan and Doris Testa

LEARNING OUTCOMES

After reading this chapter you should be able to:

- understand the different approaches to supervision
- develop skills in using critical reflection
- discuss different approaches to student supervision in fieldwork.

KEY TERMS

Administrative function
Adult learning principles
Critical incident analysis
Critical reflection
Educative function
Postmodernist perspective
Practice-reflection–theory-reflection process
Supportive function
Work-integrated learning

INTRODUCTION

This chapter will begin with a definition of supervision and the different functions supervision has when you undertake fieldwork. Different approaches to supervision will be presented including the use of adult learning principles to guide the supervision process. Then the final section will explore critical reflection as an instructive and contemporary approach to fieldwork supervision.

WHAT IS STUDENT SUPERVISION IN FIELDWORK?

Student **supervision** in fieldwork is the process where fieldwork educators assist students to prepare for, reflect on and explore practice issues in order to develop competence in their professional practice. Specific examples of practice settings are outlined in Part 2 of this book. The purpose of the supervision process is to provide students with the opportunity

for work-based learning and to begin to link theory with practice. The supervisory process is commonly described as having three principal functions:

- educative
- supportive
- administrative (Kadushin & Harkness 2002).

These three functions frequently overlap, and some functions are more dominant at different times throughout the fieldwork experience. For example, at the beginning of placement the fieldwork educator might focus more on the administrative function, providing you with access to organisational policies and protocols. The following sections detail the three functions.

The educative function

The supervisory process, for both you and your fieldwork educator, is primarily educative. The objectives of educative supervision are to promote professional competence, develop skills and understanding about practice, make the links between theory and practice, and enable you to assess your abilities using a mutual process of giving and receiving feedback about performance. For example, the fieldwork educator might suggest you read about a particular approach used at the agency. The **educative function** is demonstrated in the discussion between you and your field educator about the link between your classroom reading and practice within the organisation.

The supportive function

The **supportive function** of supervision assists you to develop, maintain and enhance a professional sense of self. The supportive process is one where the fieldwork educator acknowledges and responds to your emotional needs as these relate to the role of student. The supportive function helps you to understand the processes of an event and the impact that event might have on you. It requires the fieldwork educator to empathise with your emotional reactions, validate feelings and integrate your experience into the context of your professional development. For example, the fieldwork educator might ask you to undertake a particular task. The supportive function is demonstrated in the opportunity provided by the fieldwork educator after a task is undertaken to discuss with you your reactions to the task, including your feelings, outcomes and the process of understanding the task.

In both the educative and supportive functions of supervision, clinical reasoning is involved. Your fieldwork educator, having advanced clinical reasoning skills, will be able to give you reasons why certain actions should be taken in relation to clients or patients as well as give you feedback as to your involvement with clients or patients.

The administrative function

The **administrative function** assists you in gaining access to information and resources, and ensures your understanding and use of procedures within the agency. These will include both the formal and informal procedures in the agency. The *formal procedures* are generally documented and followed by all staff, and the *informal procedures* inform the culture of the organisation; for example, when and where lunch might be eaten, whether there's a roster for doing dishes in the agency staff room or how staff meetings are conducted.

The fieldwork educator is accountable to the agency through these procedures. It is the responsibility of your fieldwork educator to ensure that your learning process is consistent, through participation in learning opportunities within the organisation. Your fieldwork educator will also have a professional duty of care, according to his or her discipline. For example, to ensure that you are familiar with the administrative data collection requirements within the agency, the fieldwork educator might ask you to undertake some training in workplace information systems.

REFLECTION

THE CHECKLIST

Cleake and Wilson (2007) provide a useful checklist for the student and fieldwork educator to work through during the beginning phase of fieldwork placement. The checklist, given in Table 4.1, provides an opportunity to ensure that both have the same expectations of the functions of supervision. Consider the tasks in the left-hand column. Are these tasks relevant, and should you act upon them in your situation? Note relevance and action in the right-hand columns.

Table 4.1: Function and task checklist for you and your fieldwork educator

Tasks	Before placement	During placement
To validate the student both as a developing professional and as a person		
To create a safe environment for the student to reflect on his or her practice and its impact on him or her as a person		
To clarify the boundaries between support and counselling and the issue of confidentiality in supervision		
To debrief the student and give him or her permission to talk about feelings raised by his or her work		
To help the student explore any emotional blocks to his or her work		
To explore issues of difference and discrimination that may be experienced by the student		
To monitor the overall health and emotional functioning of the student		
To clarify when the student should be advised to seek professional help		
Other (specify)		
To ensure that the student understands his or her role and responsibilities		
To ensure the student's work is reviewed regularly		
To ensure that the student has an appropriate workload		

(continued)

Table 4.1: Function and task checklist for you and your fieldwork educator (continued)

Tasks	Before placement	During placement
To ensure that student activities are properly documented and carried out according to agency policies and procedures		
To ensure that the student knows when the supervisor needs to be consulted		
Other (specify)		

Source: Cleake & Wilson (2007: 57–8). Reprinted with kind permission of Cleake and Wilson © Thomson 2007

All three functions are incorporated into the supervisory process. In **work-integrated learning**, the supervisory process is also informed by **adult learning principles**. These principles are fourfold:

- the adult learner is an autonomous learner and able to direct her or his learning
- the adult learner brings life experience to learning; this life experience provides a valuable resource for new learning
- a higher level of learning is likely if the learner is able to use life experience in the generation of new knowledge
- new knowledge is directly applicable to real-life situations in the present rather than the future.

As a student and adult learner, a balance must be struck between the professional learning you need and the learning that may interest you, but the latter may not be as immediately required or applicable to fieldwork placements.

REFLECTION

THE EXPERIENCE OF BEING SUPERVISED

The questions below provide the opportunity for you to reflect on your experiences of supervision. This enables you to use past experience to anticipate some of the fears and anxieties you might face when undertaking a fieldwork placement for the first time.

REFLECTIVE QUESTIONS

What is your experience of being supervised? Consider, for example, an experience you have had in paid work experience or as a volunteer.

- What was the function of the supervision?
- What was useful about the supervisory experience?
- What was less useful about the supervisory experience?
- How might you have participated differently?

Approaches to work-integrated learning have changed over time. The following section provides an overview of the common approaches to fieldwork placement supervision, and explores in more detail the critical reflective approach to fieldwork. A key shift in approaches to supervision has been the move away from investing expertise in the fieldwork educator to a position where you, as a student, are also an active contributor to fieldwork placement supervision (Beddoe 2000). However, for the purpose of this chapter, an overview of approaches to work-integrated learning will be provided, because you may encounter a variety of approaches used in the field.

APPROACHES TO SUPERVISORY PRACTICE

Approaches to supervisory practice provide ways of linking assumptions about practice, learning and teaching in different practice settings. They act as guides in developing styles of supervision, depending on the context, the nature of the relationship between fieldwork educator and student, and the parameters of the supervisory relationship. The supervision process is by its nature dynamic, and involves a constant evaluative aspect regardless of the model used. There is an overlap across the models presented, and an assumption that most fieldwork educators may use an eclectic combination of these, depending on the supervisory relationship and the individual's supervisory style. One typology for understanding different approaches to supervisory practice is the distinction between learning by doing and learning by integrating theory and practice. For example, the category of learning by doing has models that focus on learning through observation and doing the work. The category of learning by integrating theory and practice is concerned with the interrelationship between academic and work-integrated learning. Competent practice relies on prior cognitive understanding. This is sometimes referred to as the academic or articulated model.

The following section will use this typology to provide an overview of five different approaches to supervision in fieldwork, with particular emphasis on the critical reflection approach. Table 4.2 summarises these approaches to supervision.

Table 4.2: Five approaches to supervision

Learning by doing	**Learning by integrating theory and practice**
Apprenticeship approach (Knowles et al. 2005)	Competency-based approach (Bogo et al. 2002)
Growth therapeutic approach (Siporin 1982)	Critical reflection approach (Bogo & Vayda 1986; Schön 1983, 1987, 1991)
Role systems approach (Kadushin & Harkness 2002)	

Apprenticeship approach

The apprenticeship approach gives primary emphasis to learning by doing. Knowledge, skills, values and attitudes are transmitted to you by observing an experienced professional at work, and observing, emulating or modelling your own behaviour. It focuses on retrieval and formulation of professional responses (Knowles et al. 2005). In social work, for example, the apprenticeship approach was historically how social workers learnt their craft. In this approach, a range of tools monitor the student. They may include process recordings, audio or visual tapes, peer observation, one-way screens, team or casework meetings and co-leadership in groups. The apprenticeship model generally omits reflective and conceptual activities. Table 4.3 details the strengths and limitations of the apprenticeship approach.

Table 4.3: Strengths and limitations of the apprenticeship approach

	Strengths	Limitations
Apprenticeship approach	Focuses on retrieval and professional response as modelled by fieldwork educator	Traditionally limited to fieldwork educator's practice wisdom with task focus, and therefore omits reflective and conceptual activities

Growth therapeutic approach

The growth therapeutic approach assumes that, in order to facilitate growth and change for the client, you also need to undergo a personal growth experience. It is assumed that professional helpers will have a high degree of self-awareness (Siporin 1982). You may be encouraged to be reflective, and disclose personal dilemmas that may be elicited from the practice experience. For example, your fieldwork educator might expect you to reflect on your personal reaction to a particular fieldwork experience and focus on self-disclosure rather than discussing the work. In this approach there is a danger that, having explored and identified personal issues in supervision, professional instruction may be sacrificed. Table 4.4 details the strengths and limitations of the growth therapeutic approach.

Table 4.4: Strengths and limitations of the growth therapeutic approach

	Strengths	Limitations
Growth therapeutic approach	Useful for marginal students	Process that focuses on personal reflection excluding the educational content
	Focuses on personal and professional growth	Exacerbates the power differential between fieldwork educator and student

Role systems approach

The role systems approach focuses on the interaction between you and your fieldwork educator. It is the fieldwork educator's responsibility to ensure that the most appropriate type of learning and teaching occurs. It requires negotiation of the structure, process and content of fieldwork, with the fieldwork educator disclosing to the student his or her explicit beliefs and approaches relating to fieldwork (Kadushin & Harkness 2002). Fieldwork educators will assume different roles with students, depending on their own developmental stage of being a fieldwork educator or their theoretical orientation. Table 4.5 details the strengths and limitations of the role systems approach to supervision.

Table 4.5: Strengths and limitations of the role systems approach

	Strengths	Limitations
Role systems approach	Recognises power imbalances between fieldwork educator and student	Negotiation of role expectations occurs in the context of unequal relationships

Competency-based approach

A competency-based approach defines learning objectives in specific, observable, behavioural terms. A variety of aspects of practice and associated competencies are identified and expressed as behavioural skills. Fieldwork educators are then able to rate student performance according to stages in skill acquisition, from understanding to behavioural integration. A fieldwork educator may focus on a range of competencies including, for example, values and ethics that are expressed as behavioural skills. The fieldwork educator might rate your performance for each competency, such as demonstrating congruency between one's activities and professional values (Bogo et al. 2002). Table 4.6 details the strengths and limitations of the competency-based approach to supervision.

Table 4.6: Strengths and limitations of the competency-based approach

	Strengths	Limitations
Competency-based approach	Provides clear guidelines for assessment and evidence of student's performance	Reduces the unique practice opportunities offered by specific organisations
		There may be a shift from theory to acquisition of practice wisdom

Critical reflection approach

Critical reflection directs our practice towards the political and potentially emancipatory aspects of situations that may be changed. The use of critical reflection has evolved from the questioning and challenging of knowledge generation (Fook 2002).

From a modernist perspective, knowledge is understood in a linear, scientific and rational way, by which experts generate theory, and health professionals receive and apply this theory in practice (Fook 2002). A **postmodernist perspective** challenges this understanding of knowledge. Rather than understanding knowledge from only a theoretical perspective, postmodernists incorporate other types of knowledge generated by reflecting on personal experience and culture. In work-integrated learning, being able to make the links between theory, personal interpretation and experience and culture assists in developing your practice knowledge. On fieldwork placement, these links add depth to the meaning you ascribe to practice experiences.

Critical reflection is a tool used to make these links and to begin exploring the 'taken-for-granted' reasons for 'why we do what we do' in practice. The aim of critical reflection is to understand how our assumptions, values, beliefs and taken-for-granted reasons for *why we do what we do* have an impact on practice. The use of critical reflection in supervision has the potential to lead the supervisee from surface learning to deep learning, also referred to as transformational learning (Beddoe & Maidment 2009; Giles et al. 2010). Giles and colleagues (2010) highlight the distinction between surface learning and deep learning. While surface learning is static, and asks for little critique and engagement with the learning experience, deep learning invites the learner to critically analyse new experiences and ideas and link them to previously known ideas, experiences and concepts. Table 4.7 details the strengths and limitations of the critical reflection approach to supervision.

Table 4.7: Strengths and limitations of the critical reflection approach to supervision

	Strengths	**Limitations**
Critical reflection	Provides links between theory, personal interpretation and experience and culture and leads the student to a deeper level of learning	May be challenging to students
	Assists to understand how our assumptions, values, beliefs and *reasons for why we do what we do have on practice.*	

THINK AND LINK

Chapter 3 also considers critical reflection as the fourth step of Kember and colleagues' steps to critical reflection (2008). It might be helpful to you to read this chapter in conjunction with this section, especially if you find that writing reflectively does not come easily to you.

Critical reflection assists you in exposing how practice is affected by social structures and institutions, and how they may be reinforcing oppression and sustaining inequality. Critical reflection invites you to take responsibility for personal and professional identities, values, actions and feelings, and to understand their origins. By identifying the assumptions, ideas and values that you bring to a situation, you develop new ways of working and approaching the same situation.

Critical reflection also involves the application of the skills of challenge and confrontation. These skills are used to expose the dilemmas, ambiguities and paradoxes in practice, and to move practice towards anti-discriminatory practice (Fook & Gardner 2007). For example, critical reflection may involve you in naming the dominant and missing perspectives in the critical field practice incident.

By using critical questions, reflection on practice can lead to new ways of acting, by which means behaviours, contexts and values are challenged. Fieldwork placements offer you opportunities to grow and develop professionally, which is different from classroom-based learning.

REFLECTION

CRITICAL REFLECTION

Some critical reflection questions are listed below (based on Holland & Henriot 1995). They can be used by you and your fieldwork educator to review practice, and add synthesis and evaluation to the consideration of fieldwork placement.

- Which theoretical approach have I used to inform practice?
- Whose interests does this approach serve?
- Who is being disadvantaged or advantaged by this practice?
- Why do I think this is so? Are there inconsistencies in my thinking?
- How could I do things differently in my practice?
- What are the underlying assumptions of this theory?
- What knowledge is excluded?

THINK AND LINK

Chapters 12 and 13 discuss approaches to thinking through ethical issues that are related to vulnerable clients and patients. Some of these critical reflection questions are embedded in some of the approaches included in Chapter 12, although they are not presented as critical reflections.

Striving for critical reflection

As with any learning, our ability to engage in critical reflection is a work in progress. You may not always be successful or confident in your critical reflection, so it is important to have fieldwork educators who can help you revisit critical reflection processes and hone your critical reflection skills. Critical reflection invites the health professional to recall life experiences that shape and influence how you see and experience the world. Using critical reflection takes time, commitment and a preparedness to reflect on and be aware of all that you communicate to people: your age, 'race', culture, sexuality and religious, political and social beliefs and background. The following case study provides an opportunity for both you and your fieldwork educator to analyse, reconsider and requestion the issues that arise for you.

CASE STUDY

Working with Mr Omar

Your fieldwork placement is at a community health centre. You have been working with Mr Omar for one month and find him difficult to engage. Mr Omar's interactions with you have been loud and aggressive. He consistently uses pointing and jabbing actions when interacting with you. Mr Omar has arrived at the reception desk again, asking to see you and claiming to be in crisis. This is the third time he has done this, so you have approached your fieldwork educator to see Mr Omar with you.

QUESTIONS FOR CRITICAL REFLECTION

1 What might be happening for Mr Omar? (reflection on content)
2 What is happening for you?
3 What emotions or reactions are being stirred up for you?
4 Where might these have come from? (reflection on meaning)
5 How do you understand this?
6 Are there gender, age, socio-economic or other considerations that might be having an impact on Mr Omar's or your own behaviour?
7 How could the interaction between Mr Omar and yourself be different? (critical reflection).

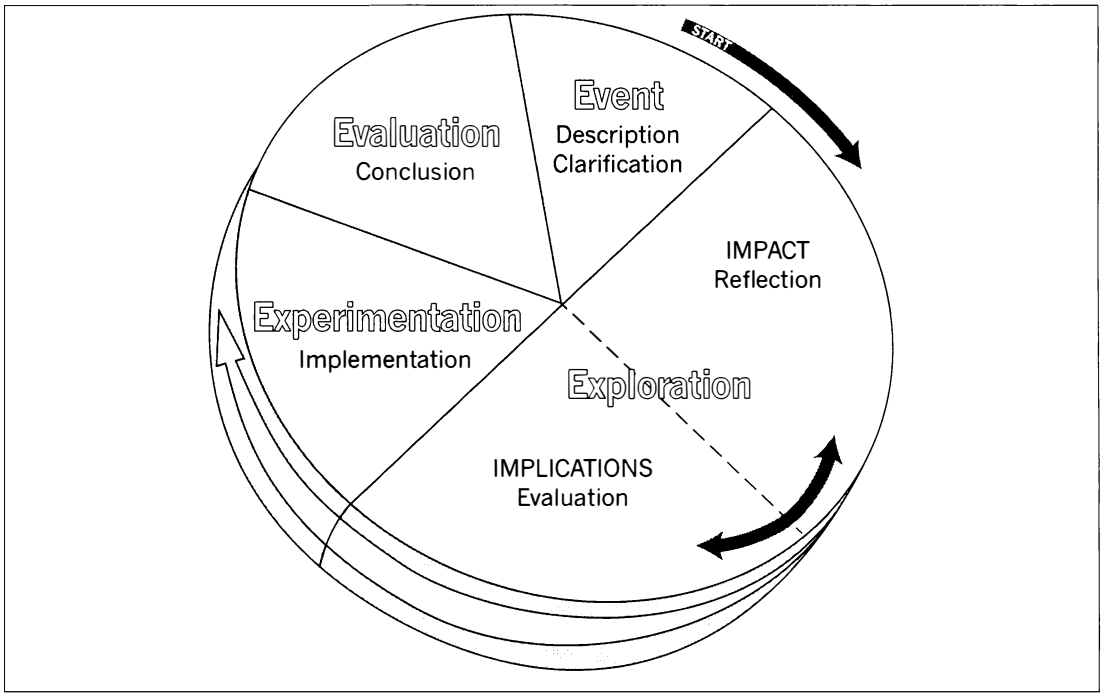
WORK-INTEGRATED LEARNING: TRANSLATING CRITICAL REFLECTION INTO CRITICAL ACTION

Learning critical reflective skills is only part of the challenge. Critical reflection on practice needs to then be followed by translation into action. Translating critical reflection into action can be challenging. Depending on one's personal life experiences, cultural background and social norms, critical reflection may be difficult for some individuals. However, these skills are central to work-integrated learning. Reflecting at the individual and community levels can take many forms; for example, for a student on a fieldwork placement this may mean challenging stereotypes, gender roles or socio-economic status. This may mean challenging the behaviour of the client, challenging the context in which you work and/or challenging the mindset of workers that students may meet in the workplace.

Critical reflection on placement requires you to work systematically through the 'work experience'. The Reflective Learning Model from Davys and Beddoe (2010) (see Figure 4.1) provides a structure to undertake this reflection to arrive at a practical outcome.

The model (Davys & Beddoe 2010) describes four stages: event, exploration, experimentation and evaluation. Each stage can be worked through with the student and supervisor. In the first stage the student considers an event experienced on placement that they want to discuss in supervision. The student is encouraged by the supervisor to tell the story about the event, clarify it in the context of placement and supervision, and identify the goal wanted from the discussion. The exploration stage requires the most time in the

Figure 4.1: The Reflective Learning Model showing the four stages of reflection to arrive at a practical outcome (Davys & Beddoe 2010)



Source: Adapted from Fook 2002

process and includes the impact and implications phase. The supervisor encourages the student to reflect on the impact of the event on their feelings, beliefs, behaviour, intuition and values. Exploring the implications of the event moves the focus beyond the student to consider the organisational context, policy, legislation, theory, protocols, legislation and professional ethics. The task of this stage is to reach an understanding of the event in relation to the learning on placement. The experimentation stage is where an explicit plan is developed about the way forward with this particular learning. The evaluation stage revisits the goal and reflects on the learning undertaken. Figure 4.1 captures this process.

THINK AND LINK

Chapters 3 and 5 also use tools for reflection. Consider these chapters together with this chapter for several approaches to reflective practice.

TOOLS FOR CRITICAL REFLECTION

The phases of critical reflection use a **practice-reflection–theory-reflection process**. During this process, students can use a number of critical reflection tools. Fook and colleagues (2000) suggest a number of writing tools that can be used in critical reflection. These include critical incident analysis, journal keeping, think sheets and narrative records.

Critical incident analysis

A **critical incident analysis** includes a reflection on a specific incident using the following steps:

1 a description of the incident and those involved
2 the outcomes of the action for each involved in the incident, including positive and negative impacts of the actions
3 a reflection on the process, naming the types of knowledge or experience that informed the actions, the skills used and the theories underpinning the actions
4 naming your learning from the incident: discipline-specific theory and knowledge; professional values and ethics; skills; personal beliefs and assumptions.

Journal

A journal is a record of significant events and personal responses to events kept throughout the length of the placement and even beyond. The formatting and purpose of the journal can differ according to the expectations of you, your university and your fieldwork educator. However, before a journal is started you and your fieldwork educator need to clarify the purpose and content of the journal, and whether the content will be shared, and by whom. For example, the university may have an expectation that you keep a journal for the duration of the fieldwork placement; however, whether the fieldwork educator can read the journal needs to be clarified at the beginning of placement.

Think sheet

A think sheet is a more structured, generalised writing exercise that encourages reflection on both behavioural and emotional responses to fieldwork placement experiences.

Narrative record

A narrative record is the retelling of events on fieldwork placement from a personal perspective. This can occur both in writing and/or conversation between you and your fieldwork educator. The retelling may include conversations with significant others and links with past or current experiences, and may also connect feelings with ideas and experiences. The narrative record tries to link the intellectual, spiritual, moral, social, physical and aesthetic dimensions of the narrative.

SUMMARY

This chapter has introduced different approaches to supervision in fieldwork placements. It provides an overview of five approaches to supervision in fieldwork, and explores in more depth a critically reflective approach to fieldwork placement. Tools for critical reflection were given including critical incident analysis, a journal, think sheet and narrative record.

Discussion questions

1 Name the different functions of supervision and provide an example of each.

2 What approaches to supervision resonate with you and why?

3 How might structured supervision include the three functions of supervision?

Portfolio development exercise: Models of supervision

This exercise is designed to be completed for your portfolio three times during your placement. We suggest you do this exercise in the first few weeks of placement, the middle of placement and then just before you finish placement. For each 'stage' of the placement write a critical reflection. Use the following questions to critically reflect on the supervision session:

› What happened in supervision? (reflection on content)

› What emotions or reactions are being stirred up for you during supervision?

› Where might these have come from? (reflection on meaning)

› How do you understand this? (reflection on theory)

› Are there gender, age, socio-economic, cultural or other considerations that might be having an impact on your own or your supervisor's behaviour?

› How could the interaction between your supervisor and yourself be different? (critical reflection)

Repeat this exercise two other times during your placement.

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CHAPTER 5

Making the Most of Your Fieldwork Learning Opportunity

Helen Larkin and Anita Hamilton

LEARNING OUTCOMES

After reading this chapter you should be able to:

- identify factors that influence your learning during fieldwork placement
- explain how your current skills, knowledge and attributes influence your personal learning opportunities and outcomes
- reflect on the actions you can take to facilitate your work-integrated learning.

KEY TERMS

Discipline-specific knowledge
Evidence-based approach
Fieldwork Learning Framework
Goal-setting
Johari window
Personal attributes
Work-integrated learning

INTRODUCTION

Health professions embed **work-integrated learning** or **fieldwork learning** into their programs as a required teaching activity. It is important that this learning be closely integrated with academic learning (Biggs & Tang 2007: 143), as it provides an opportunity for students to:

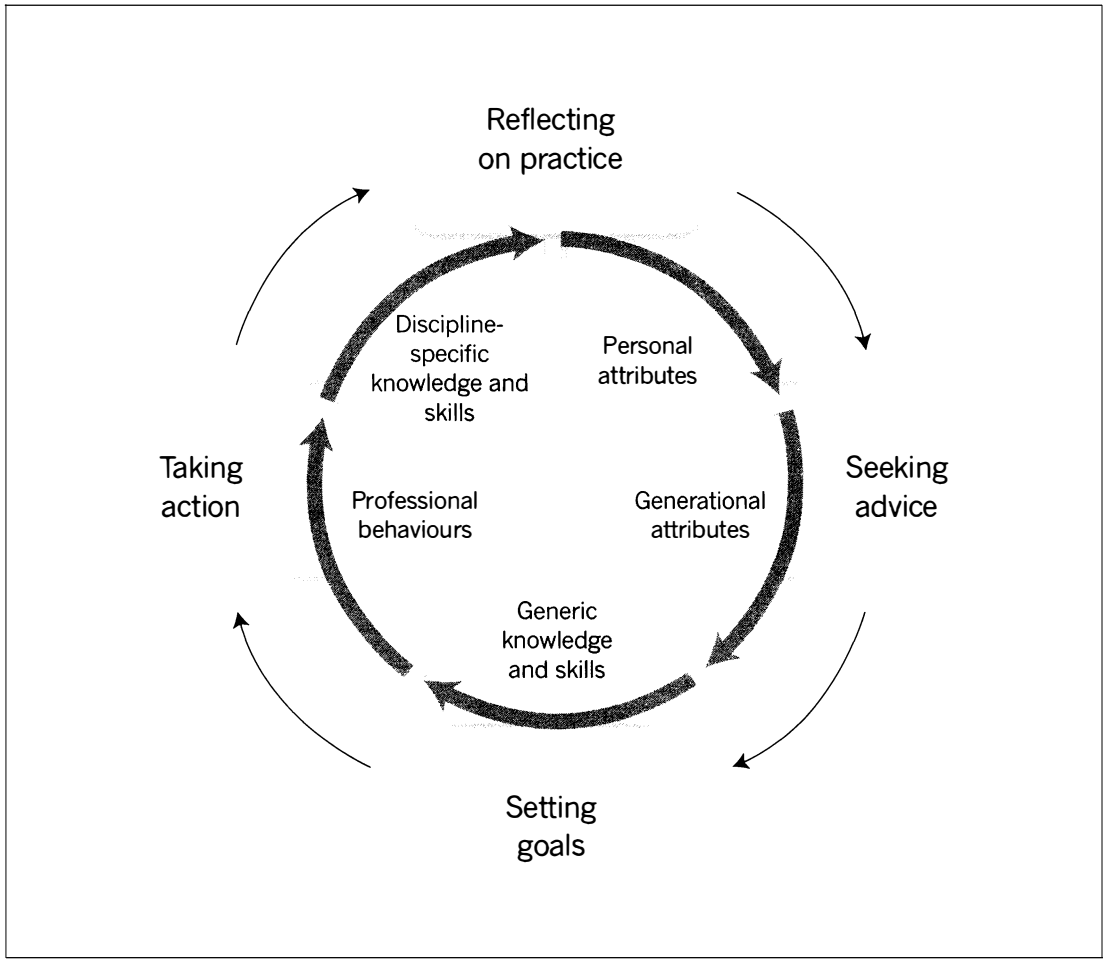
› apply knowledge and skills learnt in university in real-life professional settings
› apply theories and skills to practice in all aspects of professional practice
› work collaboratively with all parties in multidisciplinary workplace settings
› practise with professional attitudes and social responsibilities in their respective professions.

This chapter explores the factors that influence fieldwork learning, and identifies how you can make the most of your fieldwork experience. The framework described will assist you to understand your central role in the learning process, and provides strategies for promoting critical reflection and professional growth and integrating theory with practice.

THE FIELDWORK LEARNING FRAMEWORK

The **Fieldwork Learning Framework** (see Figure 5.1) describes the personal and professional resources and attributes that contribute to developing your skills, knowledge and behaviours for professional practice. It emphasises the need to be continually *reflecting on practice*; *seeking advice*; *setting goals*; and *taking action* before, during and after fieldwork.

Figure 5.1: The Fieldwork Learning Framework



The framework emphasises a continuous cycle of learning over time. Different aspects of the framework become more or less important at various times during a fieldwork placement, or between placements, as you build on prior experience and learning and continue to develop professional and personal skills. Using the framework will help you

to manage how you feel, think and act, and help you to make the most of your fieldwork learning opportunity. Throughout this chapter, specific tools are suggested that promote reflection throughout the cycle.

Personal and professional resources for learning

The inner circle of the framework consists of personal and professional resources and attributes upon which you can reflect. Each of these is described below, with suggestions on how to recognise and develop them during fieldwork learning. They include:

- personal attributes
- generational attributes
- generic knowledge and skills
- professional behaviours
- discipline-specific knowledge and skills.

THINK AND LINK

Review the information contained in Chapter 3 that outlines some of the important elements of being more reflective in your approach. Chapter 4 considers reflective practice within supervision.

Personal attributes

Before commencing fieldwork you may be concerned about your professional competence and the impact of this on your ability to perform satisfactorily. However, another important area, which is sometimes overlooked, is the **personal attributes** that you bring to the fieldwork placement. These include, but are not limited to, such things as: age and gender; learning style; cultural and family background; and the presence or not of a specific health condition or disability.

Aveling (2001) proposes that attributes such as those described above contribute to all of us being *marked* or *unmarked*, depending on the environment and context in which we are placed at any given time. For example, a male student among predominantly female students will feel marked by his gender. Alternatively, a female student will feel unmarked in this situation. Be aware of factors that might create a sense of being marked or unmarked. The unwritten norms of organisations, which define the context and environment, can be powerful determinants of organisational behaviour. A lack of awareness of these factors by you or your fieldwork educator can be a source of misunderstanding and confusion. Developing awareness through reflection and seeking advice are important steps in preventing negative or frustrating experiences.

Diversity is something to be affirmed and celebrated; however, it is important to recognise that sometimes our own and others' personal attributes (including fieldwork educators) may be misunderstood. Identifying this early in the placement helps to reduce opportunities for misunderstanding between you, your fieldwork educator and others in the workplace. Consider the following scenarios in Table 5.1.

Table 5.1: Personal attribute scenarios

I am a mature age student.	You may not be easily identified as a 'student' by other workers, or there may be higher expectations of you than may be made of younger students. Alternatively, you may relate more easily with others of a similar age.
I am a reflective learner and learn best through introspection.	Your fieldwork educator may expect you to be actively involved in fieldwork tasks, and expects you to discuss at length what you have done and why.
I am an international student and English is not my first language.	Apart from difficulties with language, your cultural and/or religious background may be different from that of others in the workplace. This may affect the way you carry out fieldwork tasks that are expected of you.
I have a hearing impairment, but don't know whether to disclose this to my fieldwork educator.	By not disclosing, you remain 'unmarked' within the workplace. By disclosing, you enable your fieldwork educator and others to make accommodations for your learning needs. There is no right or wrong way, but this will require reflection and you may also benefit from seeking advice.
My family has very high expectations of me, and I am worried that I am not going to do well.	If your primary focus is on not failing rather than on what you can learn, you will be more reluctant to immerse yourself in all of the available learning opportunities and to take risks with your learning.

Generational attributes

While it is dangerous to make sweeping generalisations, the generation into which you are born will influence your social values and learning characteristics (Hills et al. 2011). The generations born between 1982 and 2002, commonly known as Generation Y or Millennials (Prensky 2001), are thought to learn and communicate in a fundamentally different way from other generations (Oblinger & Oblinger 2005; Arhin & Cormier 2007; Nimon 2007; Pardue & Morgan 2008). While technology is increasingly being taken up by the full spectrum of age groups, if you are of the Generation Y or Millennial generation, research indicates you are more likely to multitask, favour graphics and multimedia over large slabs of text, tend to skim information rather than explore it more deeply, and prefer Google to using the library (Oblinger & Hawkins 2005; Hills et al. 2011). Hills and colleagues also argue that younger people, while respectful of authority, don't hesitate to challenge it (2011: 2).

THINK AND LINK

If you are from Generation Y, then you might be more at ease with issues raised in Chapter 10. Chapter 10 outlines specific technology-enhanced learning strategies that can facilitate fieldwork learning.

These characteristics have implications for work-integrated learning. Your learning and communication style may contrast to those of your fieldwork educator or others in the workplace, and may result in your behaviour being viewed by others as uninterested, distracted or disrespectful. Refer to Table 5.2 for some examples of this and how it can be corrected.

Table 5.2: Reframing generational attributes and behaviours

Generational attribute	Possible behaviour	May be interpreted by fieldwork educator as	Alternative action
Need to engage in multitasking and stay constantly connected.	Checks messages on mobile phone during team meeting.	The student is uninterested.	Check phone messages during breaks. If you are waiting for an important message, discuss it with your fieldwork educator.
Technologically savvy, and favours using multiple media to support learning.	Feels disconnected if fieldwork setting does not have the same technology as university or home.	Student is unable to work in the 'real world'.	Explain some of the technology that you use at university and its potential application to the workplace.
Expects instantaneous responses.	Expects to be able to meet with fieldwork educator at minimal notice.	Student is demanding and does not appreciate the supervisor's workload.	Discuss the area of concern that you have, and ask when the fieldwork educator may be available to sit down and discuss this with you.
Managing multiple priorities.	Asks to leave early to be able to go to paid work. Falls asleep during a meeting.	Fieldwork is not the student's priority, and they do not appreciate the opportunities being provided.	Determine your priorities. Plan your paid work well in advance so that you can manage the demands of fieldwork placement. Arrange to do more work over the university breaks so you can give priority to fieldwork.

Generic knowledge and skills

Students frequently juggle fieldwork and academic workload with the demands of paid work, and perhaps voluntary or community work and caring responsibilities. These other experiences provide valuable skills in areas such as teamwork, time management, negotiating conflict, managing change and leadership. Such generic work skills complement and add value to the discipline-specific knowledge and skills being learnt at university. Utilising these generic skills is a key component of optimising learning in the fieldwork setting. Make sure you recognise and value these skills and bring them to your fieldwork placement. Let your fieldwork educator know what other skills you have that may add value to the fieldwork experience.

Professional behaviours

Some of the most critical behaviours for health professionals include demonstrating a positive regard for others, being able to maintain confidentiality and having excellent interpersonal skills. It can be challenging to remain positive and to communicate effectively if the learning situation on your fieldwork placement is stressful and overwhelming.

Effective communication relies on being assertive, managing anxiety and controlling anger (Nelson & Low 2003). This can be difficult to do in a hierarchical environment, where

you are working across disciplines in the junior role of student/learner. You need to be an active listener, and speak clearly, objectively and honestly, while recognising that the other person has the right to disagree with you.

To communicate assertively, use first-person language to open your statement with 'I feel', 'I think' or 'I believe', and link it with the event that you wish to discuss. The following case study describes a typical fieldwork scenario, followed by alternative communication response examples.

CASE STUDY

Jenna, part 1

Jenna was unexpectedly asked to speak at a team meeting about one of the clients she was working with. She was quite anxious about this, particularly in light of the fact that she was asked at the last minute. Jenna tried to collect her thoughts in order to clearly outline her role and progress with her client. However, as her anxiety increased, her presentation became rushed and disorganised. The fieldwork educator took over, and finished telling the team what Jenna had been doing with the client. After the meeting Jenna felt angry with herself for not being able to think and speak clearly during her presentation. She was also angry with her fieldwork educator for putting her in that position, and then taking over.

QUESTIONS

1 Can you articulate the emotions that Jenna was feeling?

2 Have you felt like this at any of your fieldwork placements?

3 What might Jenna say to her fieldwork educator about the team meeting? (There are some alternative response types given in Table 5.3.)

Table 5.3: Alternative response types

Response type	Communication example
Aggressive	Jenna speaks loudly: *'It was completely unfair to expect me to suddenly present in the meeting today, and then take over when I wasn't able to do it properly.'*
Passive aggressive	Jenna is quiet and smiles at her fieldwork educator after the meeting. While leaving she thinks to herself: *'I should never be put in that position. What kind of fieldwork educator is she anyway? I am not going to learn anything while I'm on fieldwork here!'*
Deferential	Jenna thinks to herself: *'Well, I messed that up, as usual! My fieldwork educator knows what she's doing by asking me to present without warning. I'll just have to see if I can improve ... somehow.'*
Assertive	Jenna asks to see her fieldwork educator later, and speaks privately with her: *'As you may know, I am quite anxious when presenting, so I felt awkward when you asked me to present at the team meeting. Is it possible to have time to prepare for meetings so I can manage my thoughts better and present clearly and concisely?'*

Without reflection and advice Jenna may become stuck in a cycle of ineffective communication. Without an understanding of her own anxiety and anger she would be more likely to respond with ineffective or negative responses. By identifying her anxiety Jenna is taking steps to avoid being angry with herself and her fieldwork educator. By discussing it in an assertive manner (see Table 5.3) and considering how the situation could be improved, Jenna is taking steps to improve her communication skills in team meetings.

Discipline-specific knowledge and skills

Students develop a range of **discipline-specific skills and knowledge** through fieldwork placements and a range of classroom, online, practical learning and assessment activities. It is important to point out that there is a difference between having information and having knowledge. Seeking information for practice is different from knowing how to apply it in practice with a client; this can be a transition point where the student feels uncomfortable because they are aware of what they don't know—consciously unskilled.

A key strategy for seeking advice regarding discipline-specific knowledge is obtaining evidence from the research literature. This **evidence-based approach** to fieldwork practice integrates a systematic search for, and critical appraisal of, the most relevant evidence, combined with clinical expertise and client preferences and values, to answer a fieldwork question (Fineout-Overholt et al. 2005). Through formal education, you will be learning how to implement the five steps of evidence-based practice (Fineout-Overholt et al. 2005: 338–40):

1 question framing
2 database searching
3 critical appraisal
4 implementation
5 evaluation.

Evidence-based practice is best undertaken in the practice context. However, your fieldwork educator may lack the support, time and resources to search for new evidence in day-to-day practice (Fineout-Overholt et al. 2005). Therefore, combining information obtained through research literature with the knowledge and experience of your fieldwork educator has learning outcomes for both parties, and positive healthcare outcomes for clients.

OPTIMISING YOUR FIELDWORK LEARNING OPPORTUNITIES

To make the most of fieldwork learning, you need to continually draw from your personal attributes, generational attributes, generic knowledge and skills, professional behaviours, and discipline-specific knowledge and skills. These are your personal resources for learning. This is best achieved by continually reflecting on practice, seeking appropriate advice, setting goals and taking action for learning.

Reflecting on practice

Reflecting on practice is one of the defining characteristics of a quality professional (Schön 1995). The reflective tool, presented in Table 5.4, is based on the **Johari window** (Luft 1969)

Table 5.4: Reflecting on practice window

	Known to self	**Unknown to self**
Known to Others	**Open** I know it, can do it, can say it or show it.	**Blind** You know I don't know it, do it or show it. But I don't know what I don't know or do.
Unknown to Others	**Hidden** I know it, can do it, but don't show or say it.	**Unknown** We both can't see what I don't know or can't do.

Source: Adapted from Johari window (Luft 1969)

and is designed to develop and enhance self-awareness. The window has four quadrants: *open*, *blind*, *hidden* and *unknown*.

In this reflection tool 'I' refers to you, and 'You' refers to the fieldwork educator. We all naturally communicate many things during our interactions with others; some we are aware of, some we are not. Using this tool promotes self-awareness, so that you and your fieldwork educator can explore your combined awareness of your current knowledge and skills, which will help you *set goals* and *take action* to improve your practice (Smith 2007). You could use this tool with your fieldwork educator in a supervision session.

The *Open quadrant* includes those moments when you are aware of your skills and knowledge, and choose to share and demonstrate these with others. In this quadrant, students will not respond automatically to a question from a fieldwork educator with 'I don't know'. Instead, you can respond more positively with 'This is what I know', a more productive way of communicating.

The *Hidden quadrant* includes those situations when you choose not to reveal your knowledge and skills. Students often hide their abilities because they don't feel confident enough to use them in practice. Being able to discuss with your fieldwork educator what you can do, but are afraid to try, requires courage and trust, but it is worthwhile. Give your fieldwork educator a clear picture of how you see yourself, as this helps to develop your working relationship and opens the door to *seeking advice*.

The *Blind quadrant* includes issues of which you are unaware. Organisations often have unwritten rules of which novice health professionals are unaware. As a student it can be easy to break these unwritten rules, and it can be a shock when you are made aware of them. It can be as simple as using someone's coffee cup or as complex as acting inappropriately without understanding the complexity of an issue. We all have blind spots, and we need to develop our awareness of them. When you find yourself feeling resentful or angry about any feedback, it is wise to seek advice from someone you trust. Ask that person if he or she thinks it is possible that you were blind to your behaviour.

The *Unknown quadrant* includes all those things of which you and your fieldwork educator are unaware. You simply might not know what happened or why someone responded to a particular behaviour or comment. This can also include those areas of skills and knowledge that are difficult to practise; for example, responding to an emergency. This quadrant is the most difficult to predict.

Seeking advice

The ability to know when and how to appropriately seek timely advice is a core skill in any profession. It is a skill that requires practice. Some students are *deferential*, asking for advice too often and failing to trust their own judgment; while others are *overconfident*, failing to seek advice when they need to. The challenge is to find that middle ground; reflecting on what you honestly do and do not know is the best place to start.

THINK AND LINK

Chapter 9 is about learning from failure in fieldwork. If you have had difficulty in your fieldwork placement, read Chapter 5 together with Chapter 9.

CASE STUDY

Jenna, part 2

We continue to explore Jenna's experience of presenting unexpectedly at a team meeting. To support Jenna to better understand herself, the fieldwork educator suggested that they use the reflecting on practice window. After carefully going through each quadrant, both Jenna and the fieldwork educator were able to create a framework for a meaningful discussion about each other's thoughts, beliefs and behaviours, and consider how they might both contribute to reducing Jenna's anxiety about presenting at team meetings.

QUESTION

1 How does this solution differ from your suggestions in Part 1?

REFLECTION

REFLECTING ON PRACTICE WINDOW: JENNA'S REFLECTION ON HER OWN PERFORMANCE

	Known to self	**Unknown to self**
Known to others	**Open** I become anxious when speaking in team meetings.	**Blind** You seem to have low confidence in speaking clearly at team meetings, but I have seen you speak clearly with clients.
Unknown to others	**Hidden** I have done this before in case study presentations at university, but because this is a real team meeting I'm afraid of saying so in case I appear to be overconfident or I say the wrong thing.	**Unknown** How would I manage at presenting to a large group such as a seminar? I haven't had an opportunity to do this before, but I feel very anxious about the idea.

(continued)

OUTCOME

Jenna and her fieldwork educator agreed that it would be helpful if Jenna had time to prepare for meetings. Jenna and the fieldwork educator discussed that this was a common fear for students. Jenna's fieldwork educator said that she had observed Jenna working with clients and with other team members, and had observed evidence of specific knowledge, skills and behaviours valued by their profession. Jenna was pleased to hear that others thought she was performing well, but was unaware that she had been observed. Jenna's fieldwork educator asked to set a goal focusing on reducing her anxiety in team meetings. The unknown quadrant allowed Jenna and her fieldwork educator to explore opportunities for future practice, while at the same time reassuring Jenna that this would not be necessary for this particular placement.

Warning! Don't wait for something to go wrong first. Use this tool as a guide when planning and preparing for fieldwork placement or on a regular basis to reflect on your practice and check your progress.

Setting goals

Goal-setting involves working out where you want to be and how you might get there. Based on what you know about yourself and your professional skills and knowledge, set goals that are achievable, but which also challenge and extend you further. These should be developed in collaboration with your fieldwork educator. A simple goal-setting strategy is to write *SMART goals* (Specific, Measurable, Achievable, Related, Timely) to help you identify *how* you will achieve your goals, and *when* and *how* you will evaluate your progress. This may take the form of a formal learning contract. Be sure to review your progress, and continually re-evaluate your goals throughout your fieldwork placement.

A SMART goal for Jenna could be: 'To be able to confidently present a client report at a team meeting by the end of week four of placement.' A strategy for achieving this may be for Jenna to document her client summaries and give them to her fieldwork educator for review the day before team meetings, so there is time to amend and rehearse.

Taking action

For you as a health professional, **lifelong learning** starts at university, is demonstrated in fieldwork and is ongoing through your professional life. Acting on your agreed fieldwork learning goals is the most effective way to improve practice knowledge and skills, and help form good learning habits. Jenna identified that she is anxious about presenting in team meetings. In discussion with her fieldwork educator she was able to identify why she became anxious and create a plan to reduce her anxiety, and as a consequence improve her presentation skills. This example typifies the cycle of learning that continues throughout fieldwork, as you identify other personal and professional resources and attributes for learning.

Repeating the cycle

The Fieldwork Learning Framework cycle needs to be repeated during the placement and can assist you to prepare for your next placement by reflecting on previous fieldwork experiences.

CASE STUDY

Jenna, part 3

Several months later, Jenna is preparing for her next placement. She uses the Fieldwork Learning Framework to reflect on her previous experience to develop new learning goals in her fieldwork journal:

> Since my last placement I am feeling a lot more confident about my communication with other members of the healthcare team and also with clients (*professional behaviours*). However, my next placement is in a mental health facility and I am feeling very nervous about this. We have learnt a lot about different mental health conditions at university (*discipline-specific knowledge*) and I feel that I understand at a theoretical level what my role might be, however, I have never had any real contact with people with mental illness. I am also from a small farming community where people are not necessarily encouraged to discuss their problems, particularly the men. I am conscious that in my own family, the expectation is that you 'get on with it' and don't complain (*personal attributes*). My family are not good talkers. How am I going to manage to talk to people on placement about some of the difficulties they are experiencing? I am nervous about doing this. I need to talk to my supervisor early on in my placement about it (*open quadrant*). The agency that I am going to is a small community-based service, so I imagine that I will need to be working with other services in the area. I feel pretty comfortable about this because my paid job is at an agency that coordinates volunteers and I talk to different community agencies all the time (*communication-generic knowledge and skills*). One of the difficulties that I have had in my last few placements is managing to stay focused on just one thing at a time while at fieldwork and juggling all the other things that I have to do including work and study (*generational attributes*). My parents also expect me to go back home regularly to help out (*personal attributes*). This has really affected my energy levels in the past and I have had trouble concentrating and I get really tired. I really don't want this to happen again so somehow I need to find a way of ensuring that I am able to give it my best this time.

QUESTION

1 List some appropriate learning goals that could assist Jenna as she prepares for her next placement.

SUMMARY

The model described in this chapter is designed to assist you to identify the factors that influence your learning within the context of fieldwork. Learning outcomes that arise out of fieldwork placements may be discipline specific in nature or more related to generic skills; or they may reveal an appreciation of how personal attributes facilitate or act as a barrier to successful learning during fieldwork. The best learning takes place when you are able to reflect on, seek advice, set goals and take action in relation to these factors.

Discussion questions

1 Which of the personal and professional attributes contained in the Fieldwork Learning Framework do you feel are your strengths?

2 Which of these attributes do you feel you have had difficulty with in the past?

3 Identify examples in the past where you have communicated in the *Hidden* quadrant. Reflect on how you could have communicated in the *Open* quadrant in these situations.

4 What are the benefits of reflecting during fieldwork? What are the costs of choosing not to reflect?

Portfolio development exercise: Using the Fieldwork Learning Framework

1 As part of a fieldwork journal, start to plan now for your next fieldwork placement and use the Fieldwork Learning Framework to write a reflective piece on what are your strengths and areas for improvement. Address each of the Personal and Professional Resources specifically:

- discipline-specific knowledge and skills
- personal attributes
- generation attributes
- generic knowledge and skills
- professional behaviours.

When creating your reflective piece refer to Chapter 3 for more information that may assist you to undertake this task. Reflect on a time also when you were operating in a previous placement in the Hidden quadrant and think and write about how that felt and what it would have felt like if you were the fieldwork educator. Develop a strategy for how you can be in the Open quadrant more often.

2 Once you have completed your reflective piece, document three to five individual learning goals that you believe are relevant to you at your present level of professional development and also relevant to the clinical context in which you are about to be placed. Share these with your fieldwork educator at the beginning of your placement to gain some feedback and further refine them in the light of the feedback. Use these learning goals to guide and assist you in taking responsibility for your learning while on fieldwork. Review your progress in relation to these goals and document this in your fieldwork journal.

3 Use you fieldwork journal to reflect on your experiences throughout your placement and review your final progress against your goals. Provide evidence of how you achieved these goals. Continue this cycle for future fieldwork placements.

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CHAPTER 6

Assessment of Clinical Learning

Megan Smith

LEARNING OUTCOMES

After reading this chapter you should be able to:

- reflect upon the role and methods of assessment of clinical learning
- identify strategies to promote effective self-assessment.

KEY TERMS

Assessment	Midway assessment
Assessment criteria	Self-assessment

INTRODUCTION

Assessment is integral to your experience of your education, and is recognised as an important driver of the amount and type of your learning (Irons 2008). Although a common and familiar aspect of studying, assessment on fieldwork placement is a novel form of assessment for students who are more accustomed to exams and assignments. Strategies learnt to manage and succeed in traditional forms of assessment may not transfer successfully to the clinical environment. The aim of this chapter is to give you optimal help in preparing for assessment during your fieldwork placement. A key message promoted in this chapter is that you need to be an active partner in assessment, and develop sound skills in self-assessment.

It is important to highlight that fieldwork placements are primarily opportunities for learning, and assessment is just a measure of whether learning has taken place. You are expected to try new things and make mistakes in the course of your learning. An important strategy for a successful assessment outcome is to show that you are learning and making adequate progress against the expected criteria.

This chapter begins by highlighting the differences between assessment in clinical settings and more traditional forms of student assessment. We will then look at the criteria used to

assess clinical performance, and some examples from the range of health disciplines. Finally, we will look at how to develop your skills in self-assessment as they apply to clinical placement.

WHAT IS SPECIAL ABOUT ASSESSMENT IN CLINICAL LEARNING?

By the time you commence your first fieldwork placement you are likely to be very experienced at assessment, having completed years of schooling and university study. However, not all assessment is the same, and the characteristics of assessment in the clinical setting are very different from those in exams and assignments (see Table 6.1 for a comparison).

Table 6.1: Differences between clinical assessment and assessment in formal academic settings

Assessment in formal academic settings (e.g. exams, assignments)	Assessment during fieldwork placement
• Single submission of an assignment or one-off examination • Extended period of time to prepare which can be controlled by the student (e.g. when you study) • Retrospective assessment of material previously studied • Single assessor • Limited or no chance to respond to feedback to influence marks • Limited frame of reference for criteria, e.g. may focus on narrow area of knowledge • More concrete criteria to address • Summation of understanding of material already learnt • Theory based rather than practice based	• Continuous assessment where aspects of your performance are repeatedly sampled and have an impact on the next assessment • Developmental process, allowing feedback to be integrated • Ongoing learning occurs while being assessed • May be multiple assessors • Multiple sources of data can be used to assess performance • Limited time for preparation and revision before assessment • Assessment under selected assessment conditions is used to predict your future practice as a health professional • Assessment is contextual and less controllable. Your performance may be influenced by the patient and others in the setting • Based on practice and performance rather than theory • Multiple criteria • More abstract complex concepts are being assessed • Assesses competency for entry-level practice as well as attributes that will develop over the course of your professional experience

You might notice important differences between these types of assessments. For example, fieldwork assessment is continuous over the duration of the placement. The ongoing nature of such assessment means that you will continue to learn while you are being assessed. This is different from a final exam, which is a single task based on a defined body of material for which you are given a long time to prepare. However, during fieldwork

placement you are likely to receive formal **midway feedback**, where you are given a mark or level of achievement using the same assessment forms that will be used at the end of the placement. You then have the opportunity to respond to this feedback to influence your subsequent results. Assessment in the clinical setting also assesses a greater amount and complexity of knowledge, skills and professional behaviours than can be contained in any single assessment that you might be used to.

REFLECTION

LAST-MINUTE BEN

Ben is a third-year student who is used to completing his assessment tasks at the last minute. He has always reviewed the material covered during the semester in the week before the final exam. On his first day of fieldwork placement his fieldwork educator tests him on his knowledge of the anatomy of the upper limb while they are preparing to see a client presenting with a work injury. He has not studied this material before placement, and has had no time to prepare for her questions.

QUESTIONS

Think about your current approach to completing assessment tasks.

1 Will your current strategies be adaptable to the clinical setting?

2 What changes might you have to make?

3 What changes will Ben have to make if he is to be successful in his placement?

WHAT IS THE ROLE OF ASSESSMENT IN CLINICAL LEARNING?

Successfully negotiating any assessment task is easier when you understand the purpose of the task. Assessment of fieldwork placement serves some very important purposes that can slip your notice when you become focused on meeting criteria required to pass a placement and the marks you will receive. You need to think about each placement assessment as a piece of the bigger picture that will lead to the awarding of your qualification and, more importantly, your right to practise as a health professional. This important role of being a practising health professional means that your assessment is in the interest of many other people beyond you, your fieldwork educator and your university. For example:

- clients and patients need to be confident that their health care is being managed by capable practitioners who will ensure they receive safe and effective care
- society requires and expects that health professionals provide a certain standard of care that all members of that profession have obtained
- professional colleagues expect that those they work with can be trusted to do their job to a certain standard
- colleagues in specific disciplines expect that new members of that discipline maintain the minimum standard of care by which all members of the discipline are judged.

It is clear that being able to practise as a health professional requires you to achieve certain standards of practice, also referred to as competency. These standards form the basis of assessment on clinical placement. Many professions have defined these standards; for example, the Australian Physiotherapy Standards (Australian Physiotherapy Council 2006), the National Competency Standards for the Registered Nurse (Australian Nursing and Midwifery Council n.d.) and the Australian Competency Standards for entry-level Occupational Therapists (OT Australia 2010). Assessment of fieldwork placement, regardless of discipline, is usually based on these standards, and involves the collection of data to determine if these accepted standards or competencies are being met.

The assessment methods used to determine students' achievement of these standards vary according to your discipline. Typically, assessment during fieldwork placements will involve the completion of a form or grid by the fieldwork educator rating a student's performance. In some circumstances, disciplines have developed national forms against which students are assessed; for example, the Competency Assessment in Speech Pathology (COMPASS™) and the Student Practice Evaluation Form–Revised (SPEF-R), used in occupational therapy.

Although the use of a supervisor assessment grid is very common, other methods are used to determine achievement of standards. They can include submissions of clinical case studies, written reports of clinical situations, portfolios and logs, reflective diaries and clinical exams. In this chapter, the focus is on fieldwork educator assessments of competency, although the principles discussed will apply to these other forms of assessment.

CRITERIA AND MARKING SCALES

Although each discipline will have its discipline-specific standards of performance and competencies, there is a similarity in the behaviours and actions expected of entry-level practitioners regardless of discipline. Table 6.2 describes these typical **assessment criteria**. These criteria are often referred to as competencies. These criteria have been linked to clinical activities that fieldwork educators might observe to reveal how you are meeting these criteria. During a single interaction with a client or patient, multiple aspects of your practice may be assessed.

Table 6.2: Assessment criteria used during clinical placements, and activities used to reveal achievement of these criteria

Assessment criteria or competencies	Activities that may reveal how well you are achieving these competencies
Discipline-specific skills and tasks These are often the aspects of our disciplines that we think are most important to learn, as they are visible to someone watching our performance. They can include communication skills, taking a client's history, hands-on skills and teaching skills.	Observation of specific actions with a client/ patient Exams and tests with and without clients present Practical sessions with other students

(continued)

Table 6.2: Assessment criteria used during clinical placements, and activities used to reveal achievement of these criteria (continued)

Assessment criteria or competencies	Activities that may reveal how well you are achieving these competencies
Combining and integrating knowledge, skills and attitudes in a series of actions typical of our discipline Clinical practice is not made up of isolated skills, but involves the effective integration of these skills.	Giving you responsibility for all aspects of a client's or patient's care, and observing how you sequence and progress this care Discussion of plans for future sessions
Knowledge When you start placement it is expected that you will have a certain level of knowledge that you have gained from the theory studied at university. An expectation of placement is that you are able to determine where this knowledge is relevant and apply this knowledge to the clinical setting, and that you will build on this knowledge over the course of the placement.	Direct questioning Tests and exams Observing the application of knowledge when explaining conditions and treatments to clients Referring to relevant knowledge when explaining clients' presentation to your fieldwork educator Inclusion of a broad range of knowledge in description of reasoning processes Written reports
Professional behaviour, communication and teamwork An important expectation of you on fieldwork placement is that you will learn acceptable professional behaviours. For some students, this can challenge the ways in which they act in many other facets of their life, and they need to learn to adapt their behaviour. Being a professional also means taking responsibility for your actions and wanting to improve the quality of the service you provide. This professional responsibility means that you will develop your capacity to assess and modify your own performance.	Interactions with other health professionals Your ability to self-assess Interactions with clients Interactions with your fieldwork educator Behaviour when in group situations and locations How you spend your time when not engaged in client or patient activities Time you arrive at placement, take lunch and leave Your dress Discussions with your fieldwork educator that demonstrate your awareness of acceptable professional behaviours Examination of reflective journals and portfolios
Achieving positive outcomes for clients and not being harmful This means being safe and effective in your decisions and actions. It is important to note that as you develop, educators often provide you with more challenging situations to test your safety and effectiveness. You should be aware of the complexity of the circumstances you are being put into, and how you can adapt to these situations. You may initially be safe only to be assessed as unsafe if you don't respond to more challenging situations.	Observation by educator and by others in the healthcare setting Comments by the client Your descriptions of actions and outcomes Your need for supervision; how well they trust you to be left alone

Assessment criteria or competencies	Activities that may reveal how well you are achieving these competencies
Reasoning and thinking processes An important element of being a professional is having the critical thinking skills and reasoning processes that underpin decision making. Educators will ask you questions to encourage you to talk about and explain your thinking. Being able to describe your reasoning processes is an essential element of being assessed. Students might show all the technical skills, but be judged not to have achieved the expected level because they cannot demonstrate an understanding of the reasoning needed to monitor and guide the application of technical skills.	Direct questioning about your reasoning Written intervention plans Written case reports Patient or clinical notes Presentations to your fieldwork educator, fellow students or other health professionals about a client or patient Letters to other health professionals Discussions about clients in team meetings
Work-readiness Educators can also look at the extent to which they feel a student is ready for practice in the workplace as a new graduate. This criterion would apply more so to placements occurring at the end of the course.	Providing you with more independence Increasing time pressures Providing more complex clients or patients who are typical of a new graduate workload

THINK AND LINK

Consider the assessment criteria and activities of Table 6.2 together with the practice window (Table 5.4) in Chapter 5. What have you learnt about yourself?

REFLECTION

YOUR ASSESSMENT

Locate the assessment criteria and forms that will be used to assess your performance on fieldwork placement.

1 How do the criteria in these forms compare to those listed in Table 6.2?
2 Are there any additional criteria you need to think about?
3 What are the ways that these criteria may be assessed in your discipline?

RATINGS OF PERFORMANCE

An essential part of passing a placement is being aware of the criteria that are being used to judge your performance. Often assessment criteria have a scale against which a student's performance is rated. These may be limited to 'Satisfactory' or 'Unsatisfactory', or there may

be a more extensive scoring system. Typically, your performance is rated according to the extent to which you have met the criteria or performed expected behaviours. Depending on the assessment criteria, you will often be judged against how you are expected to be performing at a particular point in a placement. You may be performing at a satisfactory level mid-placement, but if there is no change over the course of the placement then your results at the end may be rated lower than they were previously.

Consider this example: Anne, a final year student, received good grades during her **midway assessment**. She was confident she was doing well, and didn't make a conscious effort to increase her knowledge or skills further. She continued to practise in the same way, even though her fieldwork educator gave her increasing challenges in the placement. At the end of her placement her results were lower than they had been mid-placement, because she had not developed her practice to a new level of competency in response to the new challenges. When being assessed, it is important to establish what is expected as the minimal level of performance, and how this is expected to change over the duration of the placement.

What if you fail?

It is worth clarifying the notion of failure as it refers to an assessment of fieldwork placement. Failure does not mean that you have failed as a health professional, although it may feel like this. Failure usually means that you have not reached the expected criteria within the timeframe expected. Fieldwork educators experience a considerable dilemma if a 'Fail' grade is awarded. This decision is never taken lightly, and would only be made after careful consideration of the assessment criteria, and often in consultation with academic staff from the university.

THINK AND LINK

Chapter 9 discusses failure on fieldwork placement. Consider the different student responses to failure in Chapter 9 against the practice window in Table 5.4 and the assessment criteria discussed in this chapter.

Students are often concerned that single instances of poor performance will adversely affect their assessment. Fieldwork educators seldom look at a single performance in isolation. Yaphe and Street (2003) identified that assessors of medical students formed an initial impression of students, and then engaged in a process of testing to ensure that this initial impression was accurate or needed revising. Fieldwork educators observing a student might ask themselves questions such as: Is this performance consistent with other behaviours I have seen? Has the student recognised the problem and resolved to amend it? Is this a behaviour that the student was given feedback on before and it hasn't changed?

Failing is less likely to occur if you are aware of the criteria and have understood the level of performance that is expected. It is important that you have developed your own ability to assess your performance against the criteria, and modify your performance as needed rather than being solely dependent on feedback from others.

REFLECTION

YOUR ACCEPTABLE STANDARDS

1 What sorts of behaviours and performance standards do you think are the minimum acceptable standard?
2 How are you going to establish this level of expected performance?
3 What would inadequate performance look like to you, and is your perception accurate?

DEVELOPING SKILLS IN SELF-ASSESSMENT

Self-assessment requires students to learn skills in assessing their own performance and a decreasing dependence upon external forms of assessment. An important argument for this approach is that practising health professionals are continually required to learn new information, apply this to their practice and assess how well they are performing and using this new knowledge. Boud (2000: 152) argues for the importance of self-assessment to future practice.

> In order for students to become effective lifelong learners, they need also to be prepared to undertake assessment of the learning tasks they face throughout their lives. They should be able to do this in ways which identify whether they have met whatever standards are appropriate for the task in hand and seek forms of feedback from their environment (from peers, other practitioners, from written and other sources) to enable them to undertake related learning more effectively.

Learning to self-assess requires you to seek out ways to determine the quality of your own performance and how well you are learning the skills of practice. Self-assessment skills require a sound internal understanding of the required performance, and the ability to accurately compare your own performance against the observable and published standards.

In Table 6.3, findings from research conducted with nursing students (Crawford & Kiger 1998) has been used to provide you with a framework to help you develop skills in self-assessment. Included in Table 6.3 are some case examples to guide the application of the strategies. This table is also designed to help you use the assessment of others effectively while also developing your own skills in self-assessment. You will notice that the suggested strategies change over the course of the placement as your self-assessment skills mature.

Table 6.3: Developing self-assessment skills throughout a clinical placement

Stage of the placement	Characteristics of stage (adapted from findings of Crawford & Kiger 1998)	Suggested self-assessment strategies	Case example
Beginning of the placement: adapting to the new environment	• Reading objectives, protocols • Observing and practising procedures	• Become familiar with the assessment criteria.	Toby has just started his new placement. This afternoon he will be completing his first task of conducting an assessment of a new client.

(continued)

Table 6.3: Developing self-assessment skills throughout a clinical placement (continued)

Stage of the placement	Characteristics of stage (adapted from findings of Crawford & Kiger 1998)	Suggested self-assessment strategies	Case example
	• Seeking role models to identify expected standards • Questioning and seeking reassurance • Building relationships • Acting 'like a student'	• Clarify interpretations of the criteria and how and when they may be assessed. • Identify examples of how qualified staff self-assess their performance.	Toby decides to spend the morning carefully watching his educator conducting an initial assessment, reading assessments completed by other staff in the centre and checking with his educator about whether there are any particular practices used in the centre. Toby has previously read the assessment criteria his educator will use to evaluate his performance and recognises that during his initial assessment aspects of his performance such as his communication, clinical reasoning and professional behaviour could be assessed.
During the placement: getting comfortable and seeing the opportunities for learning	• Discriminating between other staff as role models • Finding good role models • Asking more specific and probing questions to guide learning • Needing less direct supervision • Developing own standards	• Start confirming that your judgment of the expected standards is accurate. • Start making self-appraisals and testing that these are accurate. • Compare your performance against the assessment criteria.	Toby has been on placement now for two weeks, and his educator has scheduled a meeting to discuss his midway assessment. Toby has prepared for the meeting by completing his own version of the assessment. During the placement Toby has been checking how his sense of performance compares with the qualified professionals and his peers.
		• Listen and critically appraise feedback. • Compare your educators' feedback with own judgment. • Discuss differences or mismatches.	He is prepared for some differences between his own perception and that of his educators, and plans to understand any discrepancies that exist and to focus on the feedback, in particular how it affects his developing self-judgment skills.

Stage of the placement	Characteristics of stage (adapted from findings of Crawford & Kiger 1998)	Suggested self-assessment strategies	Case example
Towards the end of the placement: mastery of the placement	• Feeling comfortable about ability in the area • Acting more like a health professional than a student • Greater mastery of own performance and needing less supervision • Comparing own performance against own standards	• Continually apply self-assessment, rechecking the accuracy under new conditions. • Don't expect perfection; learn to be realistic about the standard expected at your stage. • Focus on future learning and development of practice.	Toby is feeling more confident about his ability to assess his performance, and feels he is realistic about what is expected of him. He has also implemented a number of strategies to improve his performance and learn from the outcomes of his experience. He has started to broaden the sources of data upon which to base his assessment, and is focusing on the outcomes he is achieving with his clients and their feedback. He knows there are things he still needs to improve, but doesn't think that his final assessment will hold any surprises.

WAYS OF COLLECTING DATA ABOUT YOUR PERFORMANCE

In Table 6.3, ideas were introduced that can support your developing sense of self-assessment. Below is a summary of these ideas related to sources of information about the quality of your performance on fieldwork placement. Consider how the integration of these sources of information can provide you with an overall understanding of your performance.

› *Client appraisal*: Have you ever asked your clients to give you feedback on your performance? They could provide you with valuable information on aspects such as your communication. This feedback could be direct, but you can also look for indirect markers of your clients' satisfaction, such as the comments they make to your supervisor and other staff, their keenness to come back and see you or their attendance at appointments.
› *Client outcome*: How well have you helped the client achieve positive health outcomes or the goals you have set for the time you are with the client? How long has it taken to achieve these outcomes? What changes to the client's health have occurred as a direct result of your actions, and how much have you depended on the ideas of your supervisor? It is worth noting that this source of data can be difficult when you are a member of a team where everyone is contributing to the client's outcome.
› *Fieldwork educator input*: How does your assessment of your performance compare to their expectations? How do they collect information to form their assessment? Why

do they use these methods? The emphasis here is on actively using the input of the supervisor rather than being a passive recipient.

› *Peer assessment/comparison*: How does your performance compare with that of your peers and qualified health professionals? What does this comparison tell you about your own performance?

Challenges to the use of self-assessment

Emphasising and practising self-assessment is desirable, but can also be challenging. A potential risk in not balancing self-assessment with external input is that you may miss out on input to guide you in determining acceptable standards. As a result, you may over- or underestimate the level of performance that is expected. There is the potential that poor self-assessment skills will reinforce misconceptions and perpetuate inappropriate behaviours. A further advantage of having input from others is that it provides a means for you to develop strategies to meet desired criteria. Without this input you may be unsure of what to do.

On the other hand, when you are being assessed by someone else, it is easy to become dependent upon this assessment. You may try to act in a way you think will lead to a positive assessment. It is easy to value external feedback highly and value self-assessment less. The risk of relying on external feedback is that you learn to please others rather than respond to the task in front of you. In future practice, where direct supervision and feedback will not be as readily available, you may be unable to determine how well you are performing and how to respond if problems arise with your performance.

THINK AND LINK

Chapters 7 and 8 discuss placements where self-assessment may be an important part of the fieldwork placement assessment. Consider the issues raised in this section of Chapter 6 in relation to issues raised in Chapters 7 and 8.

Molloy and Clarke (2005) identified that students tended to view their educators as experts who diagnosed and helped to fix problems, and adopted a passive or received approach to assessment. This was in spite of the student's previous experience and skills in being able to self-appraise. Molloy and Clarke also identified that fieldwork educators also saw themselves in this diagnosis role. The particular challenge is to recognise where the opportunities to engage in a dialogue with clinical educators exist, and to introduce your own self-appraisal. Although early in practice a more guided approach may best support you, it is less desirable as you mature. A further challenge in self-assessment can be the impact of cultural and language differences, particularly if you don't feel comfortable critiquing or confronting the opinion of a teacher or person in charge.

There are times when there is going to be a mismatch between your self-appraisal and a clinical educator's appraisal. Rather than viewing this as a failure of self-assessment, it is important to reflect upon and explore with your fieldwork educator why your individual expectations may have been mismatched. Without this approach it is tempting to undervalue self-assessment. Not discussing the different expectations between yourself and your fieldwork educator may also result in you overvaluing your own opinion, and you may

mistakenly attribute any mismatch to feelings that you have not been adequately assessed on or received adequate or useful feedback for, or that personality clashes exist between you and the educator.

In spite of the challenges, learning to self-assess is important. Assessment is an integral component of clinical placements. An understanding of the purpose of the assessment, the criteria used for the assessment and an active engagement in the assessment process will all contribute to an enhanced and positive learning experience.

SUMMARY

Models of clinical assessment are usually based on standards expected of qualified health professionals. Assessment on fieldwork placement involves the collection of data on your performance from multiple sources and integrating these to give a complete understanding of your readiness for professional practice. The ability to accurately self-assess is as critical to learning on clinical placements as preparation for clinical practice. Learning to self-assess is a skill to be learnt in the same way as learning to practise in your discipline. Self-assessment on fieldwork placements is challenging, and requires active effort from students and their supervisors.

Discussion questions

1 Are you aware of the assessment criteria that will be used to assess your performance on fieldwork placement?

2 How might your current views and approaches to assessment have to change to prepare you for assessment in the clinical setting?

3 How are you going to develop your skills in accurate and critical self-assessment?

Portfolio development exercise: Self-assessment

This chapter has highlighted the need to be able to self-assess. Reflect on a successful experience you had on a fieldwork placement. Describe how you knew that you were performing good work. If you were relying on your supervisor feedback, suggest some alternative methods you can use to self-assess on your next placement.

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CHAPTER 7

A Model for Alternative Fieldwork

Rachael Schmidt

LEARNING OUTCOMES

After reading this chapter you should be able to:

- discuss how alternative fieldwork can augment your professional skill acquisition and broaden professional knowledge
- describe the elements of support essential for enhancing student supervision in an alternative fieldwork model.

KEY TERMS

Alternative fieldwork
Community-building project work
Community neighbourhood program
Competent self-directed learner
Conventional fieldwork placements
Fieldwork education
Host centre
Information pack
Occupation Wellness Life Satisfaction (OWLS) program
Peer fieldwork performance evaluation
Role-emerging fieldwork
Self-evaluation
Tutorial programs

INTRODUCTION

Increased health student numbers have placed pressure on conventional fieldwork placements (Fortune et al. 2006), especially in urban clinical centres (Barney et al. 1998). '**Conventional fieldwork placements**' are defined as those placements where the student has a fieldwork educator from the same profession, and placement occurs in a setting where the profession of the fieldwork educator has had a presence for many years. In response

to increased student numbers, innovative models of fieldwork have evolved to creatively meet service gaps and to provide challenging and relevant fieldwork placements that develop professional skills and competencies (Kirke et al. 2007). These innovative fieldwork models have a number of names, including 'alternative or role-emerging fieldwork' (Thew et al. 2008), 'non-traditional or nonclinical', or '**alternative placements**' and '**community projects**' (Overton et al. 2009). **Alternative fieldwork** is often located in less traditional locations, without direct profession-specific services, thus requiring an innovative approach to student supervision (Thomas et al. 2007). Alternative fieldwork has an impact on your role as a student and the practice skills you acquire. Part of your student role is to educate the host staff of your role and the potential skills you can offer within their service. You must take responsibility for identifying your specific learning objectives as dictated by the fieldwork service and location.

Background

Alternative fieldwork provides you with a wider variety of learning activities. Unlike clinical fieldwork, alternative fieldwork often occurs in the community, where identified gaps in services are addressed by student-directed projects to enhance and build on an existing service (Overton et al. 2009; Jones et al. 2011). Known as **host centres**, typically the services offering fieldwork placements rarely employ staff from your specific health professional group. You may not have ready onsite access to your specific health profession. It is likely that your host services employees may not have a clear understanding of the professional role or the breadth of services your profession has to offer. Your student role involves educating the host staff about your profession. As the name implies, **role-emerging fieldwork** suggests that the student-driven activities demonstrate and communicate the potential of your professional role within the host centre, to raise the community's understanding of your profession's service possibilities, and in doing so encourage employment for future graduates (Adamson 2005; Overton et al. 2009; Jones et al. 2011).

Alternative fieldwork placements are often located in non-urban settings, which may mean there is distance between you and your discipline-specific fieldwork educator or remote supervisor. Distance communication demands active input from you and your remote supervisor (Barney et al. 1998). In the absence of onsite discipline-specific fieldwork educators, onsite student support is provided by generic staff acting as host facilitators/educators in facilitating student projects with appropriate resources and local knowledge.

Remote discipline-specific supervision is typically provided by a combination of periodic site visits, and regular electronic and phone contact, and is optimised if student and educator actively collaborate. Ensuring that you feel well supported by your educational facility and the hosting centre relies on adequate fieldwork preparation. Fieldwork placement orientation should be undertaken early to ensure all stakeholders are familiar with the combination of roles and responsibilities. In rural or remote environments where you are required to leave your home base, assigning small groups of students to one placement, to work collaboratively, to provide peer learning and social support may ease the issues of separation from family and any social isolation that can have an impact on the success of the fieldwork experience.

THINK AND LINK

Chapter 22 gives some practical advice on how to prepare for rural and remote placements.

You are more likely to be successful in fieldwork if you are a **competent self-directed learner**. Additionally, alternative models of fieldwork are best suited to students who are nearing graduation, as you are more likely to have developed a better understanding of your professional identity.

COMMON ATTRIBUTES THAT YOU ACQUIRE FROM ALTERNATIVE FIELDWORK PARTICIPATION

Self-directed learning and managing stress

Your success in community building projects and role-emerging fieldwork hinges on your ability to cope and manage your own learning, especially as your daily activities may not be supervised as closely as in clinical settings. Thomas and colleagues (2007) recommend maintaining a daily journal to document and review activities, reflect on learning goals, to plan and manage time, to articulate your decision-making and problem-solving skills, and to set goals. Regular journaling assists in developing confident communication skills. Confident communication skills are of particular benefit when advocating for effective supervision from offsite educators, seeking resources from your host centre and educating fieldwork staff and clients (Jones et al. 2011).

THINK AND LINK

For more information on maintaining a daily journal, see Chapters 3 and 4.

REFLECTION

GAPS IN LEARNING

- What strategies do you currently use to identify your gaps in learning?
- How do you ensure that the information you have gathered to address fieldwork issues is relevant, current or trustworthy?
- How would you explain your profession to another person?

An independent learner

Ongoing fieldwork supervision should assist your professional skill via a combination of graded educational challenges and provide ongoing support both professionally and socially (Barney et al. 1998).

Those students with well developed self-directed learning skills, who are confident and competent adult learners, tend to engage in the challenge of community-building projects. Challenging fieldwork can foster **lifelong learning** in practice to develop competence and confidence in clinical decision-making (Doherty et al. 2009). As a fieldwork student, take every opportunity to develop your communication skills through actively discussing the successes and challenges of your daily sessions with host workers and remote discipline-specific fieldwork educators, to enrich your fieldwork experience. Developing a clear sense of your intended professional identity and role will assist you to thrive within the role-emerging model of fieldwork. Your success in alternative fieldwork will improve your employment opportunities within this environment or similar location as a graduate (Barney et al. 1998).

THINK AND LINK

As the internet becomes globally accessible, keeping in touch with others via online social media technologies has become easier for students placed in remote fieldwork environments. Chapter 10 discusses online technologies that can be used to keep in touch with others, as well as sites that provide information on evidence for your professional knowledge and skills.

Communicating about your profession and establishing your professional identity

Being paired with another fieldwork student provides peer support and enhances student collaborative learning. Active collaboration with peers may involve shared skill-based learning, information exchange and collaborative reflection on practice that assist in developing clarity of your professional role. **Community-building project work** in particular provides an opportunity for you to talk about your role and work with aligned professionals to illustrate your profession's contribution and to demonstrate your competence as a productive team member (Thew et al. 2008). For instance, in a setting that does not receive occupational therapy services, you (if you are an occupational therapy student) can practise articulating to those who are not familiar with it what occupational therapy can offer within that specific fieldwork environment. Learning to communicate with staff, clients and their families about your professional role develops confidence and this strengthens your professional identity.

As a student, you should take every opportunity to practise describing your professional role to potential clients/hosts. When appropriate, engage in professional exchanges with your host staff to learn more about the role differences and any overlapping professional skills and thinking. This will enhance your professional thinking, language and identity.

ENHANCING THE LEARNING EXPERIENCE WITHIN AN ALTERNATIVE FIELDWORK PLACEMENT

The most challenging aspect of any alternative fieldwork exercise is how best to support the student in developing their professional identity. Thomas and colleagues (2005) have cautioned that role-emerging placements can be challenging for students whose knowledge

of their professional role is not defined. The following section provides practical ideas for support that can help you work in an alternative fieldwork placement.

Clear goals and understanding of aims of fieldwork

The university should commence fieldwork planning well before the placement starts. The university and host centre/s should ensure the learning outcomes are identified to match the service gaps or projects identified by the host centre. To facilitate orientation before any student placement, an exchange of **information packs** will help all stakeholders understand the specific fieldwork-related roles, goals and expectations. The host centres should be informed of the intended length of the fieldwork, the assigned students' names and contact details, the fieldwork goals, the student role descriptions, a brief discipline-specific profile and the expectations of the services to be driven by the student cohort. The student should have access to a host centre profile informing them of the host service purpose, relevant personnel and potential service activities.

Each student should articulate clear learning goals designed specifically for each setting early on in the placement. Defining the student role prior to commencing fieldwork will mitigate unrealistic expectations, especially within an environment where workers may not have specific professional service knowledge.

As a student, it is wise to contact your host fieldwork facilitator to ensure you are expected on the days assigned, that you have all items required to arrive safely and you are prepared for work. Keeping everyone informed facilitates timely exchange of information and can extend the learning possibilities for all stakeholders.

Be active in your learning

Clarifying your fieldwork objectives and your student role early in the placement reduces anxiety and enhances a feeling of engagement. Although not ideal, where an orientation activity is omitted you should request assistance in orientating to your fieldwork environment, including being introduced to the relevant personnel within your first week of placement.

As alternative fieldwork rarely provides discipline-specific fieldwork supervision, it is your responsibility to actively participate in all fieldwork activities, including proactively seeking supervision when required. You may be required to independently target the relevant professional and practical skills you wish to develop during placement, to actively self-monitor your own performance evaluation, and to initiate research and discuss relevant literature with peers and facilitators to support your learning. Where available, utilise student peers to practise assessment activities, seek performance feedback, discuss intervention session outcomes, practise your interview questions and discuss case studies to develop your clinical reasoning and to link theory to practice through reflection (Courtney & Wilcock 2005).

Supporting alternative fieldwork through a tutorial program

Specifically designed **tutorial programs** are essential in supporting student learning, providing fieldwork direction and challenging student knowledge. Regular tutorial activities (delivered face to face or online by discipline-specific tutors or fieldwork educators) are

designed to enhance skill development, reflection on your learning and professional thinking. Tutorial activities allow you to reflect on your practice roles, engage in theory-in-practice reasoning, discuss case studies and share fieldwork experiences with other students to understand your professional purpose.

Active participation in your fieldwork-based tutorial activities will assist you to apply and critique your practice-based learning and to hone specific knowledge and skills within the practice setting. Regular tutorial sessions also provide your educators with opportunities to monitor your progress, challenge your clinical reasoning, assess your coping strategies and observe your practice techniques.

Supervision and facilitation

Feeling supported as a student is paramount. Fieldwork students feel most supported when they perceive they have ready access to their onsite facilitators and offsite discipline-specific fieldwork educators, either in person or electronically. Communicating indirectly, via email or telephone, requires a higher level of skill for all stakeholders to ensure the message is truly conveyed and supervision is supportive. Therefore, building rapport between yourself and your discipline-specific fieldwork educator may take longer and require more effort to ensure you are both being heard. Scheduling regular, formal phone supervision enables both your discipline-specific fieldwork educator and you time to prepare. Preparation facilitates a reflective approach to your learning. Email communication offers an informal support, especially for random questions requiring quick answers for unresolved difficulties, issues or specific discussion.

In preparation for professional practice, initiate your own fieldwork questions before meeting with your host fieldwork educator or your discipline-specific educator. Independent research, reflecting and critiquing the literature content (critical thinking) adds depth to the discussion with your educators (and peers). Critically thinking and discussing relevant literature develops your critical analysis skills, addresses gaps in knowledge and links theory with practical clinical reasoning skills.

REFLECTION

YOUR PROFESSIONAL ROLE

How would you describe your professional role to someone who did not know about your profession? Can you explain your professional role in plain language, that is without professional jargon?

Discipline-specific fieldwork educator visits

Where practical, periodic site visits by a discipline-specific fieldwork educator are ideal. These may be undertaken by a clinician working in an aligned area or location, or by an academic professional. To optimise these periodic supervisory sessions, planning before the site visit should include a clear agenda, including problem-solving and specified learning

outcomes. Onsite supervision provides you and your discipline-specific fieldwork educator with an active exchange of professional information, practice skill evaluation and clinical thinking through observation, demonstration and discussion. Periodic discipline-specific fieldwork educator site visits also provide an informal opportunity to network with host staff, thus building stronger alliances between fieldwork and the educating facility and establishing clearer professional roles for present and future students.

Peer mentors

In fieldwork settings removed from discipline-specific supervision, student peer support can provide great support. The informal support offered by student peers or student mentors can reduce anxiety. A student mentor who has recent fieldwork experience can assist with your orientation, provide insider knowledge to enable you to seek appropriate resources and deal with placement issues. Student mentors often provide a non-threatening form of support and ease the pressure on the host (generic) fieldwork educator (Hurley et al. 2003).

THINK AND LINK

Chapter 8 discusses interprofessional learning fieldwork. In this type of fieldwork, the student does not always have a discipline-specific fieldwork educator. Read about interprofessional learning, and compare this type of fieldwork to alternative fieldwork placement.

Your evaluation

Evaluating student performance in alternative fieldwork settings can challenge the remote supervisor. A peer student evaluation program, if well counselled, provides insightful feedback and professional skill development. Coaching students to self-monitor and undertake peer and **self-evaluation** could occur during the tutorial program where incremental skills training is provided to develop effective peer evaluation aligned to specific learning goals. Learning to provide constructive student-driven feedback takes practice. LoCicero and Hancock (2000) recommend both a final and a midway evaluation. The midway feedback allows time to highlight issues and set achievable goals for the final half of the placement. Participating in a peer evaluation provides additional experience, as you experience being both the evaluator and the evaluated, which broadens the skill set of any student.

THINK AND LINK

For more information on self-assessment see Chapter 6.

OWLS program

To exemplify the strengths and challenges of an alternative fieldwork model, the **Occupation Wellness Life Satisfaction (OWLS) program** is presented in the following case study.

The OWLS program is one working model that aims to develop student skills as lifelong independent learners (Courtney & Wilcock 2005; Diener 2006). Designed by Deakin University, the program originated as a relevant, challenging non-traditional fieldwork experience for occupational therapy students within regional Victoria (Diener 2006).

The OWLS program places students in diverse community-based settings where occupational therapy services were identified as a service need. Designed initially as a role-emerging model, the program aims to provide student-driven services in nonclinical regional settings. The OWLS experience challenges all students to identify specific learning needs related to refining skills and competencies, develop autonomous evidence-based research skills, collaborate in remote supervision, and initiate and build professional networks.

CASE STUDY

The OWLS program

The OWLS program was designed to provide student-driven occupational therapy services in 'areas of unmet needs and to expand services to keep pace with the community needs' (Diener 2006: 3). The OWLS fieldwork aims to extend the range of the student's professional, generic skill base and competencies and encourage critical thinking desirable for proactive community-based practice (Barney et al. 1998; Thew et al. 2008).

The OWLS program is part of the fieldwork experience at Deakin University and all occupational therapy students undertake an eight-week OWLS program in either their third or fourth year. The OWLS program runs a weekly tutorial program and student pairs attend two subsequent days in two host services. The majority of host community-based services do not have access to professional specific services. The OWLS students receive daily onsite support from non-discipline-specific facilitators and discipline-specific remote supervision is provided by Deakin-employed occupational therapists (Courtney & Wilcock 2005).

Current community enthusiasm ensures a selection of mainstream schools and community-based services willing to host OWLS students. In schools, student-driven projects are directed towards skill development of school-age children, either individually or in groups. Within the community sites, student-driven programs are linked to health promotion, work-skills programs or leisure-related services.

The OWLS program provides a breadth of experience to encourage student skill attainment, such as thinking creatively, juggling work roles in two diverse settings, time management and preparation for therapy sessions. A weekly OWLS tutorial program addresses specific **fieldwork education**, including core skills such as establishing students' roles, designing, facilitating and evaluating student-run activities, administering assessments, analysing data and report writing, exploring practice models in health promotion and program evaluation, reflective practice and constructive peer evaluation.

OWLS fieldwork performance is peer evaluated using an Australian Student Practice Evaluation Form (University of Queensland 2009). OWLS students learn to evaluate their own fieldwork performance and practise student **peer fieldwork performance evaluation** and feedback. The tutorial program ensures constructive peer feedback is practiced as an evolving professional skill. Additional assessment includes fieldwork reflective exercises, literature reviews and class presentations.

The weekly tutorial is augmented by remote discipline-specific supervision. Student feedback and support is provided electronically with scheduled onsite supervisory visits. Additional supervisor visits are activated as required, depending on each student's role and autonomy. A student peer mentor program provides regular non-threatening peer support, early orientation to the fieldwork setting and alleviating student anxiety and facilitator pressure.

QUESTIONS

1 How would you prepare for an alternative fieldwork placement located a distance from your 'home' address?

2 Have you experienced an alternative fieldwork placement? If so, what was the most valued skill you acquired?

Tips for engaging clients when on placement

The following are tips for alternative fieldwork placements:

- *Be alert to nonverbal behaviours of your clients*: These provide essential information about how a person is managing in their physical and social environment.
- *Keep your clients engaged*: Take the time to discuss the intended goals with your client group, prior to commencing a chosen activity. Informing your client group of the intended intervention goals will assist them to understand your clinical reasoning which may enhance their motivation and choice making.
- *Be prepared when working with young children*: Even the best-laid plans may be thwarted by unscheduled changes, especially with children. To plan for the unexpected, ensure your 'playbox' is well stocked so you can be creative. Having three simple games that can be adapted (according to age) ready at any time can assist you when caught on the hop.

CASE STUDY

Eliot

Eliot is halfway through her alternative fieldwork program. She describes her first full-time placement as being challenging but exhilarating. *Already halfway through and there is so much to know!* She particularly enjoys the peer exchange with the other OWLS students each tutorial, especially the reflective activities related to the successes and challenges of fieldwork practice.

Currently the tutorial content is aimed at administering a new paediatric assessment and an innovative approach to engage challenging children. The content comes just at the right time, as Eliot has recently received four new referrals at the regional school where she is placed on Tuesdays and Wednesdays. The majority of her fieldwork planning occurs on Mondays, when she has access to discipline-specific educators, student peer support and university resources.

At the primary school, Eliot and her fellow student Jo have been invited by the physical education (PE) teacher to design and facilitate two graded perceptual motor programs (PMPs) for the early year primary children. The students discuss their ideas with the PE teacher, who is very keen to learn more about their role in the school and to ensure that all his pupils are challenged appropriately by the PMP activities. Eliot enjoys the weekly PMP challenge of designing appropriate fun activities that challenge a range of physical skills within the same age group. As each school day is busy, Eliot and Jo like to plan ahead to ensure their sessions are task focused and optimise the goals set for the children.

Additionally, the students plan to undertake an assessment with a new pupil during a supervisory visit. In anticipation of performing in front of their remote supervisor, the students practise assessment procedures on each other early that morning. Eliot booked the multipurpose room and informed the teacher of the appointment time and the purpose of the pupil's assessment. Eliot intends to work on the assessment report after school, when access to the school's computers is more likely.

Eliot also attends a **community neighbourhood program** on Thursdays and Fridays. The program is directed to building parenting skills for local families. At this OWLS placement Eliot is teamed with student peer Michael. Together they have met with the neighbourhood director to discuss the parameters of designing a staff information sheet and a parents' group activity program being run in a local park. To help them prepare, Michael and Eliot watch a DVD on positive parenting skills during morning coffee. Coincidentally, this aligns with a recent tutorial on program development and evaluation, so they feel they have some good ideas to discuss in the forthcoming parents' planning group.

Both Eliot and Michael are feeling very positive about their involvement in this community setting. They have begun to connect with some of the parents attending their third Friday Healthy Cooking group. In the cooking group, a student-initiated discussion has generated some potential poster designs with captivating message ideas for an upcoming health promotional event in the local shopping precinct. The parents are keen to collaborate with the computer-savvy students in designing a series of posters addressing Healthy Shopping Choices. In the afternoon, the students meet with Jill, their peer mentor, for a second time. During the mentoring session, the students work on the content of a staff information package while sharing stories about their fieldwork experiences, being careful to use only first names to maintain client confidentiality. The students confide in Jill that although they are more confident working with the parent groups, they are still having difficulty articulating their potential professional role within this particular environment. Their mentor suggests presenting this dilemma at the next tutorial day and so they plan to undertake some preparatory research beforehand.

QUESTIONS

1 What generic skills are being developed by Eliot?

2 Are there any discipline-specific skills that Eliot is learning? What are they?

SUMMARY

Alternative fieldwork models expose students to a breadth of fieldwork environments and related work cultures that expand their professional thinking and knowledge. Students gain a broad range of generic and discipline-specific competencies that will assist them become confident and resilient professionals. Working in less traditional settings provides real-time opportunities for students to develop an insight into how other professional groups think and act within a specific setting, and this helps clarify their own role as distinctive from, but also often complementary to, other disciplines. Alternative fieldwork programs require considered preparation, empathetic supervision and collaborative teamwork to provide supportive and challenging fieldwork for students. A positive experience in alternative fieldwork programs equips the future graduate with a diverse range of professional skills, an insight into non-traditional settings and an attitude of how to thrive as a health professional working in complex practice environments.

Discussion questions

1 If you were assigned the role of student peer mentor, what approach would you take in providing support to your assigned students in fieldwork?

2 In an alternative fieldwork setting, how you would learn about other professional roles in your setting or team?

3 What are the steps you would take, if you were placed in an alternative fieldwork environment, to learn a profession-specific approach to an assessment procedure or process?

Portfolio development exercise: Developing professional behaviours

1 *Professional communication skills*: Prior to fieldwork placement, practise describing your professional role in plain language so people who may not be familiar with it can learn about your profession's breadth of service. Practise aloud with your peers so you are confident in your presentation.

2 *Developing professional knowledge and skill*: Within the first week of fieldwork placement, identify your learning goals for this placement. Share this list with your remote supervisor and onsite facilitator early in the placement. Identifying your learning goals early focuses the fieldwork experience and identifies required fieldwork resources needed to expedite your skill development.

3 *Developing a lifelong learning approach relevant to the practice setting*: To develop independent research practice, initiate your own literature search relevant to your fieldwork/or enquiry prior to each supervisory session.

4 *Developing professional evidence-based practice skills*: Augment your time with your supervisor/s by initiating an exchange or reflective discussion related to current literature to explore the link between theory and clinical practice to develop your critical reasoning.

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CHAPTER 8

Interprofessional Learning in the Field: Multidisciplinary Teamwork

Nick Stone

LEARNING OUTCOMES

After reading this chapter you should be able to:

- discuss the key interprofessional learning concepts and principles
- explain why interprofessional learning has become essential for all health professionals
- identify important factors that can help and hinder interprofessional learning
- raise self-awareness about your own interprofessional beliefs, assumptions, and preferred and non-preferred interaction styles
- identify strategies to use your own IP strengths and to continually improve your capacity to enhance multidisciplinary teamwork.

KEY TERMS

Collaboration
Interprofessional learning
Professional stereotypes
Teamwork

INTRODUCTION

Successful healthcare practitioners need to collaborate across a range of different professions. This collaboration does not happen automatically, and can be challenging because of the different traditions, approaches and emphases often present in multidisciplinary settings. This chapter presents cases showing some of the challenges that can arise as well as strategies that have been shown to be successful in managing them. Some of these cases show that lack of collaboration can make the difference between life and death. Like any sort of 'intercultural' encounter, good strategies include recognising and challenging negative assumptions and stereotypes that might exist between health professions. We look at

key features of successful interprofessional learning (IPL), as well as different conditions and strategies that enhance teamwork success. A range of tried and tested IPL outcomes and activities are outlined, which support the reflective practice skills underpinning IPL. Suggestions for assessment include an advanced activity that adapts a valuable model from the intercultural competence field.

CASE STUDY

Teamwork in adversity

The following case study is based on a true story about the challenges that can arise during interprofessional fieldwork.

You've just driven three hours to arrive in the small coastal town where you have volunteered for a rural interprofessional fieldwork placement. There you are joined by a student from another health discipline who you have not previously met. You're sharing accommodation together, and will need to work closely throughout the two weeks to successfully complete all the tasks. You're quite excited but also a little nervous because the main assessment task—a community-based project—will rely heavily on you being able to work well with this total stranger.

On arrival you greet the other student but immediately get the impression that she is not very interested in interacting with you. This is a bit puzzling: you thought that because this was a voluntary placement other students would also be quite motivated. Over the first days you try to engage her, asking her about her course, her career interests, how her discipline might approach managing the different healthcare conditions you encounter each day. She still seems uninterested, only talking with her 'same discipline' preceptor by herself.

After a few days she reveals that:

1 She didn't really want to do this placement but had to make up her 'required' rural placement time.
2 She doesn't seem to believe she can learn anything useful from another student, much less one in your discipline.
3 She wants to complete the community-based project separately, with each person doing different parts on their own.

QUESTIONS

1 How would you react to the co-worker's comments? What are the likely consequences of this reaction?
2 What are other possible responses and their likely consequences? Discuss this in pairs and try to reach agreement on a single best choice of action.
3 How would you describe this student's attitude? What assumptions (or stereotypes) does she seem to be making about your discipline, teamwork and interprofessional learning? How would you challenge these assumptions?
4 Which health disciplines do you think might (or might not) have been involved and why? What stereotypes exist about these two disciplines? How accurate are these stereotypes?

5 Could you have done anything to avoid the situation in the first place? If so, what?

6 What health disciplines might *not* be able to learn anything valuable from other health disciplines? Justify your response in discussion with others.

7 Should IPE be voluntary? What are some points for and against it being voluntary?

8 What beliefs about professional hierarchies are you aware of (real or imagined; for example, that certain disciplines are superior, deserve more power or authority, or know more than others)?

Epilogue: The 'loner' student took a bus home after two days. The other student liaised closely with students in the nearest town about one hour away and very successfully completed the placement.

PROFESSIONAL STEREOTYPES

Although often seen as something to try to avoid, stereotyping is a natural way for humans to understand how different people can be classified into groups. They are 'cognitive shortcuts' that help manage lots of information and are helpful when they are used mindfully. Table 8.1 outlines some helpful and unhelpful approaches to **professional stereotypes**.

Table 8.1: Stereotypes: Helpful and unhelpful approaches

Helpful	Unhelpful
Conscious: 'My beliefs about pharmacy students may not apply to my next encounter.'	Automatic or unquestioned: 'All pharmacists are backroom pill pushers.'
Descriptive: 'Funding models and workforce realities mean most doctors can't spend much time with each patient.'	Evaluative or judgmental (usually negative): 'Doctors don't care much about patients.'
Accurate: 'Nurses tend to consider emotional as well as biomedical aspects of patient health.'	Little/no basis in evidence: 'Nurses make decisions based mainly on their feelings.'
A 'first best guess', in the absence of other information: 'Occupational therapists probably need good empathy skills.'	No starting point at all: 'I have no idea what OTs do.'
Modifiable and flexible: 'From what I've seen so far, physiotherapists seem more competitive than other students.'	Rigid or set in stone: 'No-one can tell me that physios are good team players.'

Adapted from Adler, N. J. (2007) *International Dimensions of Organizational Behavior*, Thomson South-Western, OH

When stereotypes remain fixed, automatic and judgmental, they can form the basis for what could be called professional 'ethnocentrism'. Just like nations and ethnic groups, different health professions are made of cultures, or shared beliefs and values. Some of these values will be common to other groups, such as patient wellbeing being prioritised

over more trivial matters. Even shared values may be expressed in different ways such that they seem foreign to outside professions, or even to other sub-disciplines within a single profession. The legitimacy of acupuncture, for example, is debated within the medical (and other) professions. Some values may be specific to certain professions, such as the degree to which strictly biomedical approaches should exclude alternative models that include a stronger emphasis on socio-cultural and spiritual **determinants of health** and wellbeing.

REFLECTION

For each of the professional qualities listed below, choose three health or social care professions to rate out of 10 (1 = not at all, 10 = a great deal). You may like to compare your own beliefs with general stereotypes.

	Profession 1:	**Profession 2:**	**Profession 3:**
Good communicator			
Knowledgeable			
Good leader			
Good practical skills			
Competent			
Independent			
Team player			
Arrogant			
Modest			
Warm, empathic			
Decisive			

WHAT IS INTERPROFESSIONAL LEARNING?

Sometimes the health and social care professions seem full of confusing discipline-specific in-group language, acronyms and terms. Clarifying what we understand by certain terms with our colleagues is particularly important for successful interdisciplinary **teamwork**. Ensuring you understand each other, such as checking for meaning or paraphrasing, helps to reduce misunderstandings which can easily cause team conflict, dysfunction and fragmentation. A good example is the variety of interpretations about terms such as '**interprofessional learning**' (IPL) and '**interprofessional education**' (IPE).

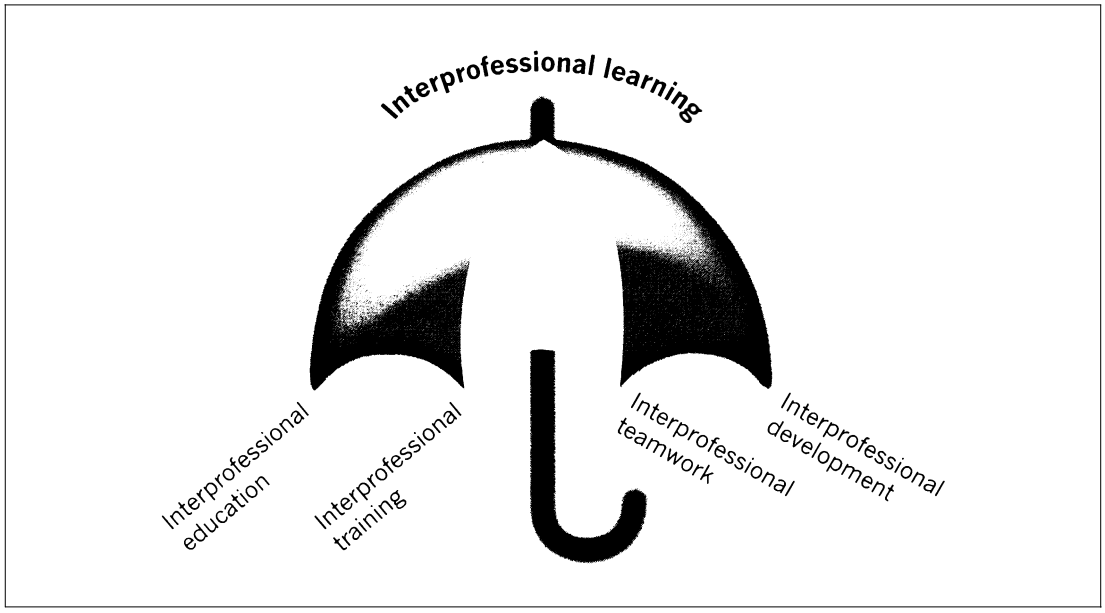
REFLECTION

- What is your understanding of the term IPL? How might strengthening IPL, in pre- and post-registration settings, affect the costs (financial and otherwise) of providing healthcare?
- What experiences have you had so far (or seen or heard of) that relate to IPE or IPL?

A recent 'snapshot' across health agencies and universities in Victoria revealed a wide range of interpretations about what IPE means (Stone & Curtis 2007). The most common definition (by about 40 per cent of respondents) involved students simply being co-located together; for example, sitting in the same lecture theatres, potentially with no interaction at all. Only a handful, less than 5 per cent, mentioned that IPE should explicitly include **collaboration**, interprofessional practice and teamwork as central goals.

IPL tends to be used as an 'umbrella' term (see Figure 8.1 below) by many practitioners working in the area. It is an important choice because it places top priority on people *learning* in teams *with*, *from* and *about* each other, regardless of disciplinary background.

Figure 8.1: IPL umbrella terms



IPL can be seen to include IPE, as in pre- and post-registration courses, continuing professional development or training, as well as all the informal opportunities that arise to learn with, from and about other health professionals across the career lifespan. IPL is also often considered to include interprofessional practice (IPP), in recognition that effective health practice necessarily involves ongoing learning. A useful IPL definition that has been widely adopted is:

> Occasions when two or more professions learn with, from and about each other to improve collaboration and the quality of care. (Barr et al. 2006)

Some definitions also include the patient, client or carer as a part of the IP team. This reflects advances in technology, pharmaceuticals and professional knowledge that mean some simpler treatments can take place in the home, often including patient self-management.

REFLECTION

In what ways could patients, clients or carers be considered part of the healthcare team? What does this imply about the model of care being adopted?

WHAT IS IPL *NOT*? MYTHS AND REALITIES

Just as there are many different interpretations about what IPL means, there are also some common myths and misunderstandings about IPL that deserve attention (see Table 8.2):

Table 8.2: Myths and realities of IPL

Myth	IPL means all healthcare situations should be addressed by a multidisciplinary team.
Reality	There will always be certain health conditions and issues that can be appropriately managed by individual health professionals and single disciplines.
Myth	IPL means everyone in the healthcare team has the same power to make important decisions.
Reality	Differing professional scopes of practice and expertise, legal responsibilities, disciplinary and traditional hierarchies mean that some people in healthcare teams will always have more authority than others in particular decisions.
Myth	IPL is an idealistic fantasy that is too difficult to achieve in the real world.
Reality	IPL already 'exists'—there have always been examples of excellent IPP in the field and occasionally in education programs. However, there is now a worldwide recognition that IPL is not only desirable but essential for the emerging models of healthcare.
Myth	IPL will blur professional identities and cause confusion about roles and responsibilities.
Reality	Learning more about the roles of other health professions actually helps to clarify and strengthen one's own professional identity and place within the healthcare systems. This is similar to how travel abroad and experiencing other cultures usually helps to provide better perspectives on your own culture.
Myth	IPL will lead to a lowering of professional standards that will compromise the quality and safety of healthcare.
Reality	IPL leads to better communication and workplace relations and is employed as a measure to improve the quality and safety of healthcare.

REFLECTION

Identify possible sources for each of the myths outlined in Table 8.2. Are there any circumstances where they might be true? In your view, do the reality claims all seem valid?

WHY INTERPROFESSIONAL LEARNING?

There has been growing recognition that effective health and social care now requires the active collaboration of a range of health professionals. Multidisciplinary teams are well-recognised as the most appropriate way to manage the chronic and complex health conditions that constitute the major 'burden of disease'. For example, Australia's National Health Priority Areas are (see www.aihw.gov.au/nhpa):

1 cardiovascular health and stroke
2 cancer control
3 mental health (with a focus on depression)
4 injury prevention and control
5 diabetes mellitus
6 asthma
7 arthritis and musculoskeletal conditions.

REFLECTION

Which health professions would typically be involved in the treatment of each of these National Health Priority Areas? Which professions would be involved in their prevention?

Are there any areas that would not require effective interprofessional collaboration?

Just as importantly, and arguably more so, efforts towards the prevention of these diseases also demand effective multidisciplinary health teams. So far, however, most courses include little deliberate interprofessional preparation. If students graduate with good teamwork skills it is likely to be the result of personality and chance factors rather than by strategic intent. The costs of absent or *ineffective* interprofessional practices can range from mild to catastrophic. A 'mild' example might be an unsatisfying workplace in which there is little sharing of knowledge or trust among the different professionals involved. This can lead to unnecessary duplication of services, communication breakdown and other inefficiencies.

A more serious case was the Bristol Royal Infirmary Inquiry (www.bristol-inquiry.org.uk) in the United Kingdom which found that in the early 1990s poor interprofessional communication and teamwork were major factors leading to an infant death rate that was about double what would have been expected. Since this inquiry, and subsequent health system and service improvements, the infant death rate at the infirmary dropped from 29 per cent to 3 per cent (*The Guardian* 2004).

SURVIVING THE 'KILLING SEASON'

Australian research by Haller et al. (2009) appears to confirm what has been called the 'killing season' in the United Kingdom (Creswell 2009). This happens when an influx of medical trainees arrives at hospitals—in around February in Australia—and rates of serious complications are twice as high compared with later in the year. Haller et al. found these preventable errors happened regardless of trainees' levels of clinical experience. They believed that unfamiliarity with the new environment—for example, hospital rules and procedures, location of patient information and roles of other health professionals—was leading to 'breakdown in communication and poor interprofessional interactions, two well-identified causes of errors and undesirable events ...' (2009: 5).

Their recommended improvement strategies included interprofessional meetings and training, similar to those adopted by aviation and other 'high reliability' industries such as nuclear power and offshore oil production, where training in teamwork and free communication are regarded as essential to reduce the risks of preventable errors (McCulloch et al. 2009: 109).

These examples may appear extreme. However, there are a number of very clear, long-term trends that also demand much more and better IPL. The ageing population means there is already a shift from episodic, 'one-on-one treatment' in acute settings towards community-based and ambulatory care in non-acute settings such as in the home. As mentioned above, multiple disciplines are now often needed to work together with clients to manage chronic complex diseases. These include preventable, so-called 'lifestyle' diseases such as cardiovascular, pulmonary and metabolic diseases such as diabetes, as included in the National Health Priority Areas listed above. It is now also widely agreed that 'management' of these diseases needs increased attention to preventative approaches, such as health promotion, education and community capacity building. These approaches take account of the social determinants of health in a more holistic fashion. These approaches also rely on effective collaboration and coordination not only across the health and social care professions, but across other industries and sectors such as corrections and justice, multiple levels of government and the community.

REFLECTION

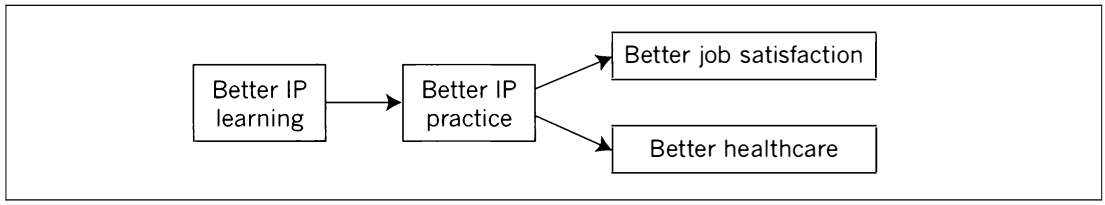
What is meant by 'upstream' factors in healthcare? Identify examples of upstream and downstream factors for a specific disease. To what degree is it a health professional's responsibility to help prevent disease? Are some professions exempt from this responsibility? Discuss.

DOES IPL 'WORK'?

We first need to clarify what we mean by 'work'. In promoting IPL, we assume causal links between IPL, IPP and improved health outcomes. That is, by implementing and improving

IPL, we expect a consequent improvement in the capacity of health professionals and, in turn, in health indicators among individuals and communities. These links are illustrated in Figure 8.2.

Figure 8.2: Links between IPL and outcomes



To 'prove' such links exist, especially using traditional biomedical research models such as randomised controlled trials, has been challenging to say the least. It is questionable whether these models are appropriate when trying to evaluate complex social systems (Stone 2006a). There is, however, a diverse, solid and growing research evidence base to support the assumption that successful interprofessional practice (IPP) can lead to significantly improved outcomes as outlined below:

› interprofessional team and health service effectiveness and efficiency
› job satisfaction among interprofessional team members
› competencies in expressing respect for and understanding of the roles of health professional colleagues, and most importantly
› patient health outcomes.

These links rely on IPL being implemented *successfully*. Stone (2006) included his research from almost a decade of work in a range of IPL programs with a review of international related literature to identify some points of agreement for successful implementation. In summary, the evidence suggests that IPL is likely to be successful when specific conditions are being met, as outlined below:

› focuses on clear learning objectives that are understood, valued by and shared by all participants
› explicitly aims to improve patient/client health outcomes
› is flexible enough to target general content relevant to all professions involved, but also includes discipline-specific components
› pays explicit attention to learning about teamwork, and assessing the dynamics of interprofessional collaboration (especially self-assessment)
› project planning is jointly negotiated by students, clinical supervisors and local community stakeholders
› involves participants who have chosen to participate and who have been actively involved in making arrangements
› provides multiple opportunities for students to engage in IPL throughout their education and professional life (a competency of lifelong learning)
› is situated in applied settings such as fieldwork, rather than academic classes.

WHAT MAKES GOOD TEAMS WORK (AND GOOD TEAMWORK)?

In a situation such as interprofessional fieldwork, attention to factors that enhance team functioning are especially important. There is often 'nowhere to hide' out in the field. Team members typically rely on each other in order to get the job done. David and Roger Johnson (1999, 2009) have been actively researching collaborative learning and teamwork for nearly half a century and are regarded as world leaders in this area. The brothers have identified five key conditions for successful teamwork that are very relevant and useful for guiding IPL in the field:

Positive interdependence: 'swim together or sink together': Team members understand that they must learn together to accomplish the goal; they need each other for support, explanations and guidance. Rewards and incentives relate to the group, not individuals.

Individual accountability: The performance of each group member is assessed against a standard, and members are held responsible for their contribution to achieving goals. This means there is no room for 'social loafing', or people not pulling their weight.

Promotive interaction: The tasks require that students interact closely, rather than, for example, each person going off to complete a fragment of the task individually.

Group processing: Groups use language that shows they understand important group processes so they can discuss and reflect on their collaborative efforts and develop ways to improve.

Development of small-group interpersonal skills: Most people do not automatically develop the skills required for successful teamwork. These skills include giving constructive feedback, reaching consensus, decision making, negotiation, conflict resolution and involving every member (adapted from Johnson & Johnson 1999).

REFLECTION

TEAMWORK CONDITIONS

Is it realistic to expect all of these conditions to be evident in teamwork? Which ones seem easiest and hardest (and why)? What sorts of behaviour help and hinder these conditions? What issues and obstacles might arise and how could you address them?

Simply trying to avoid conflict, or expressing disagreement impolitely, are rarely helpful in team situations, even though they can be tempting options amid the stresses typical of health and social care delivery. In fact, a hallmark of excellent teamwork is accepting that tension and disagreement will inevitably occur, then working out ways to resolve the conflict while preserving respectful working relationships. Interprofessional fieldwork is especially prone to interdisciplinary differences of approach and opinion; it is therefore essential to develop effective strategies for dealing with these differences.

Recognising these realities of human nature and group dynamics, the Johnsons have recently focused on areas such as 'constructive controversy' and using team conflict to help teams effectively and creatively achieve their goals. This idea encourages people to develop

the skills to disagree respectfully and seems much more realistic than assuming everyone needs to agree on everything all the time.

They offer eight practical guidelines for controversy in teamwork:

1 Be critical of ideas, but not people. You can challenge the ideas of the other participants while still affirming their competence and value as individuals.
2 Understand that if someone questions your ideas, it is not a criticism of you as a person.
3 Focus on coming to the best decision possible (i.e. in the client's interest), not on 'winning' or 'saving face'.
4 Positively encourage everyone to participate and to share relevant information.
5 Listen to everyone's ideas, even if you do not agree.
6 If unsure, restate what you think someone means (paraphrase).
7 Try to understand both sides of the issue. Show you can see the issue from the opposing perspective.
8 Be prepared to change your mind if the evidence clearly indicates so (adapted from Johnson & Johnson 2009).

CASE STUDY

An illustration of structured post-fieldwork IPL

Following are some excerpts from an IPL end-of-placement tutorial discussion. This was a structured session designed to guide reflection and self-assessment on the students' IPL experiences during their two-week program. The students belonged to four different health disciplines and were placed together at an alcohol and drug service in a regional town.

As you read through, try to identify which of the Johnsons' conditions and guidelines for effective teamwork (above) are suggested. Also try to work out which disciplines are represented (S1–4 denotes students from each discipline, PM refers to the Project Manager and author):

Discussion

S1 It was actually easy for me to work with the others because they were just blatantly honest with each other (laughter) no matter what you said. I think a sense of humour helped in making sure we were all comfortable.

S2 We definitely learnt a lot from each other.

S3 I really enjoyed getting to look at three (other) disciplines. I tried to imagine what it would be like to be only working with one other discipline but I couldn't. I wrote in the online discussion that we all saw a patient from (the service) and then we all sat around and did a case conference. We all put in our two cents which was really good. It felt like we were being interprofessional.

S2 We all had common goals with the community-based project, but because we all come from different perspectives we all had different ideas on what it would be about. We went through a flat stage where it was going to end up being a 50–page document, and we had to cut it and cut it. Things that S4 thought was important,

say about joints or something, I would go 'Joints? Who cares?' and just delete it. And then S4 would come back and put it back in. It was really hard deleting stuff because we'd only known each other for five or six days and we didn't know how each other would react. So we had to just swallow our pride and say 'Go for it, delete what you want.' It was a really interesting procedure.

S4 And learning about your own strengths and weaknesses and learning about how best to use other people's strengths and weaknesses, to get the project done ... S1 was really busy doing typing and getting information together.

PM So (discipline 1) students are good for typing? (laughter)

S4 That's generalising, but it is my weakness.

PM (Discipline 4) students are good at inviting themselves around to other people's places to eat.

S2 (Discipline 3) students are pedantic... It's a very interesting experience.

S3 (Discipline 2) students do all their work in the first few days then just lie on the bed...

PM You guys are the first group of four, so what advice would you give other students (going into that situation)?

S4 It's a really good dynamic, it allowed a fair bit of flexibility.

S3 We didn't always work together.

S4 Sometimes we worked in two, threes or fours. Whatever was easiest.

S3 We had a timetable and we just said 'Well you just go and organise yourselves'

S2 I think an advantage we had was that our preceptors were so easy-going, like we would turn up ten minutes late, it's a country way of life. One day I went with S4 who introduced me to the (same discipline preceptor) and he said 'Oh, I thought I was having a (discipline 3) student but it doesn't matter'. It made it really nice to have a really flexible timetable.

S2 I think we made the most of having all the different disciplines. We had lots of really lengthy discussions about each other's professions and what we all do. We made the most of it.

QUESTIONS

1 Consider the following questions in small groups or in pairs:

2 What factors appear to have made this placement so satisfying for all concerned?

3 Both Case 1 and Case 2 allude to health professional stereotypes (both light-hearted and otherwise). Identify other health profession stereotypes in Case 2, as well as any others that you or others may hold.

4 Discuss the usefulness, accuracy and limitations associated with these stereotypes.

ASSESSING IPL FIELDWORK

Assessment is a powerful driver of learning so it is important to closely match the assessment, or even integrate with target competencies or key learning objectives. Self-assessment is a particularly powerful method to maximise and consolidate the learning gains involved in IPL. The list in Table 8.3 offers a range of IPL sample objectives that form the basis for a number of subsequent activities, including self-assessment methods.

THINK AND LINK

Refer to Chapter 6 for more information on assessment criteria, as well as issues related to self-assessment.

Table 8.3: IPL sample objectives

IPL fieldwork objective and examples
'Umbrella' competency: to continue developing the attitudes, knowledge and skills that contribute to successful interprofessional practice
Examples of interprofessional attitudes
• interest in, and commitment to the key principles of IPL • resilience to persist with IPL even when it may present extra challenges • willingness to exchange skills and knowledge with other health professionals • valuing collaboration as a preferred option, when possible • inclination to value and respect others' contributions, as well as respectfully challenging them, when appropriate • interest in learning about, with and from other health professionals • humility, e.g. being open to suggestions from others, even when they challenge your own discipline's training and traditions • respect for the perspectives of different health professionals, even if you don't understand or disagree with them • being prepared to compromise when in the interest of smoother teamwork and patient wellbeing
Examples of interprofessional knowledge
• awareness of one's own preferred and non-preferred ways of approaching tasks • awareness of the evidence that effective IPP benefits patient safety and health outcomes, as well as practitioners' job satisfaction

(continued)

Table 8.3: IPL sample objectives (Continued)

Examples of interprofessional knowledge

- awareness of professional stereotypes and how to challenge unhelpful ones
- knowing the roles, scopes of practice and capabilities of other health professionals
- understanding appropriate referral protocols and procedures
- knowledge of factors that enhance and inhibit interprofessional collaboration
- knowledge of processes of group formation, teamwork and collaboration
- understanding issues and sensitivities specific to various health professions
- understanding the complexity of many health issues: that there may be a number of different valid perspectives, models and approaches to healthcare
- recognising the sorts of health issues that are best addressed through IPP

Examples of interprofessional skills

- the ability to quickly establish a positive, client-focused working relationship with other health professionals
- actively communicate trust and respect for colleagues
- negotiating roles and responsibilities to establish clear shared expectations
- communicating problems and possible solutions in timely, diplomatic ways
- expressing own needs and concerns in the appropriate way, time and place
- accurately self-assessing own IP skills (identify strength and improvement areas)
- engaging in reflective discussion focused on IPP with a range of colleagues
- making an active contribution to collaborative tasks (e.g. case conferencing, planning projects, conducting evaluations or research)
- encouraging others to actively participate in collaborative activities
- facilitating conflict/tension resolution
- empathic listening (e.g. attentive body posture and facial expression, showing an understanding and respect for another's point of view)
- maintaining harmonious working relationships while under stress
- checking for meaning, for example paraphrasing or summarising what someone else has said, especially in 'high stakes' situations
- in the face of distractions, being able to guide health team's attention to focus back on the patient's wellbeing

ENSURING A GOOD START TO IPL FIELDWORK

The following advice has proven valuable to many other students. You may need to adjust or ignore some points, depending on the context and nature of your IPL fieldwork/placement experience. Similarly the timing will vary—it may suit you to do this the week before your placement or on the first day. Ideally there will be an academic or administrative facilitator who has some IPL insight and experience:

- Start establishing a positive rapport with your fellow students by holding a face-to-face meeting, a teleconference, or an online chat or asynchronous discussion forum.
- Exchange contact details and a little about your personal and academic backgrounds, including what you think is most important in IPL and any particular interest areas.
- Discuss logistical arrangements such as travel and accommodation (if relevant), timetables, negotiation of shared learning tasks, any concerns, issues or information that is still needed.
- Establish a positive working relationship by clarifying your respective expectations and hopes for the placement.
- Identify where your respective expectations and learning objectives are similar and different, such as discipline-general and discipline-specific areas.
- Discuss how you might manage to accommodate everyone's core goals and where you are prepared to make compromises.
- Anticipate possible placement problems and generate problem-solving strategies. Make sure you know what to do if things go wrong, such as personal health or safety issues, or if the placement is not meeting your expectations.
- Familiarise yourself with the principles of effective IPL and teamwork (see above), the sample learning objectives (see above) and identify any terms language or meanings that are unclear.

IN-PLACEMENT REVIEW

It is essential to allocate pre-set times during placements dedicated to evaluating progress so far, reflecting on student IPL and identifying any challenges and ways to manage them. In 'normal' practice, there are typically few opportunities for practitioners to meet and discuss interprofessional practice. When left to chance, such conversations tend not to happen in the context of busy healthcare provision. It is usually a false economy to only hold meetings when something goes wrong—by then it may be too late to fix a problem that pre-emptive action could have addressed. As in healthcare itself, prevention is often far more effective and efficient than waiting for a problem to unavoidably present itself.

During a typical fieldwork placement there should be at least one in-placement review involving preceptors from all relevant disciplines, and preferably at least one a week. This is one of the few opportunities fieldwork educators will usually have to reflect on their own IPL and that of their students: they typically find the experience very rewarding. They can also use the opportunity to clarify and collect material for student assessment requirements.

Students often need to 'gently' lead the way here, in terms of setting up meetings and focusing on specific IP aspects of the placement experience.

The purposes of the in-placement review can include:

- providing a structured mental space and time to review the placement
- ensuring both fieldwork educators and students touch base with each other, clear up any questions, raise and address issues
- sharing and discussing experiences and impressions so far and relating them to learning objectives and/or placement competencies
- assessing the extent to which students have had the opportunity to address interprofessional learning objectives (see Table 8.3)
- identifying any 'gaps' in student learning or interest areas and making plans to 'plug' them.

REFLECTION

FREQUENTLY ASKED QUESTIONS (FAQ) AND ANSWERS (A) ON THE IN-PLACEMENT REVIEW

FAQ: Who should be involved?

A: Both preceptors and students.

FAQ: Should it be directed by fieldwork educators?

A: No. Students should take as much initiative in raising topics or issues as fieldwork educators. Only students can represent their own experiences, needs and interests.

FAQ: How long should it go for?

A: About an hour should be sufficient for the formal review process; however, there should be continual discussion and informal review processes throughout the fieldwork placement.

FAQ: What preparation is required?

A: Students should address the items below before participating in the review.

Consider for reflection the following:

1. Make some notes on your reactions and impressions of the placement so far.
2. What have been the most interesting things you have learnt so far?
3. What have been the most difficult aspects of the placement so far?
4. Which IPL objectives have you been able to address most?
5. Which IPL objectives would you like to address but have not had the opportunity to so far?
6. How could your fieldwork educator(s) help make the placement more satisfying?
7. How could you help to make the placement more satisfying?
8. Other issues, needs or comments.

POST-PLACEMENT DEBRIEF AND REFLECTION

Ideally this will take place at the very end of the fieldwork placement while everything is fresh in your mind. Some suggested activities follow in Table 8.4.

Table 8.4: Post-placement objectives and activities

Objective	Activity
To share and reflect on the placement experience	Write down 2–3 highs and 2–3 challenges of the placement. Then in turns, share one or two of these experiences from what you have just written down.
To review the placements in terms of the given student learning objectives	Look at the list of example IPL objectives and identify which you addressed more, and which less, than others. Do you have any related additional objectives you addressed or feel would be relevant?
To identify issues or problems that arose, as well as possible or actual solutions applied	Identify problems and issues that arose, how you tackled them and what you have learnt that might help in future similar situations. Identify scenarios that could be used for PBL to help prepare future students.
To review the fieldwork placements with reference to the principles of collaboration and the literature on interprofessional education and practice	Review the Johnsons' conditions and guidelines as well as the factors that facilitate successful IPL (all above). For each activity, identify what you witnessed, or saw a lack of, during your placement that related to the various points. Most important of all, what have you learnt about your own IP skills, knowledge and attitudes.
For students to co-present, in pairs, any formal assessment tasks (for example, a community-based project)	Student groups present the products of their projects.
To identify ways that you might continue your interprofessional education	How might you be able to continue your interprofessional education even in the absence of structured programs focusing solely on IPL? Is it likely that one placement will have long-term effects on the development of your IPP related knowledge, skills and attitudes? What opportunities could you find or create to consolidate and extend your IPL?

* All information needs to be treated confidentially. You should feel safe being open, even if it is not all positive news.

ADVANCED INTERPROFESSIONAL COMPETENCE

Milton Bennett (1986) developed the Developmental Model of Intercultural Sensitivity (DMIS) that is now widely used to describe people's experiences as they progress from stages of cultural 'ethnocentrism' to 'ethnorelativism'. This model can help understand how

the 'culture' (attitudes, values, beliefs, traditions) of one health profession can be perceived by others in increasing stages (Stages 1 to 5) of interprofessional competence (see Table 8.5).

Table 8.5: Stages of interprofessional competence

Stage	Description
1 Denial	Being comfortable only with the familiar. Not keen to complicate life with 'cultural differences'. Not noticing much cultural difference around you. Remaining separate or isolated from others who are different.
2 Defence, reversal and polarisation	A self-protective attitude to your own thoughts and feelings about culture and cultural difference. Aware of other cultures around you, but with a low understanding of them and fairly strong negative feelings or stereotypes about some. This can lead to unhelpful stereotyping, mistrust and/or a tendency to negatively judge different cultures. 'Reversal' is the opposite of defence: You feel that another culture is better and tend to distrust, and be judgmental of, your own culture. Polarisation is a type of psychological splitting of others into two extreme 'poles' or categories, e.g. right/wrong, us/them, correct/incorrect, intelligent/ignorant.
3 Minimisation	Aware that other cultures exist all around you, with some knowledge about differences in traditions, practices and beliefs; you no longer put them down. You assume people from other cultures are pretty much like you under the surface. You assume you understand the situation as well as a person from another culture does. This correlates with a 'colour-blind' approach to cultural diversity.
4 Acceptance	You are aware of how your own cultural background affects your values and behaviour. You recognise your own culture is just one of many valid ways of experiencing the world. Other cultures' ideas and behaviour may seem strange, but you realise their perspective can be just as valuable as your own. Being curious and interested in other cultures, you seek opportunities to learn more about them.
5 Adaptation	You recognise the value of having more than one cultural perspective available to you, and are able to 'take the perspective' of another culture to understand or evaluate situations in either your own or another culture. Able to deliberately adjust your behaviour to act in appropriate ways in different cultural contexts.

It is important to note that people are not fixed at a single level, and can move between stages, depending on the situation. For example, people who are very tired and/or stressed tend to revert back to more automatic behaviour such as defence or polarisation. Overall though, most people tend to operate within one or two stages until (and if) they progress to higher levels.

SUMMARY

This chapter has covered some issues and effective strategies involved in strengthening IPL. Students and professionals who undertake IPL are often confronted with their own and others' stereotypes of how people from other disciplines think and behave. For a successful IPL placement, students need to learn how to work effectively in diverse teams. This involves accepting that there may be a number of valid approaches to managing the same healthcare situation. Fieldwork placements offer the ideal opportunity to improve IPL because it is there that true interprofessional work can be observed and practised.

Discussion questions

- What are your assumptions about IPL?
- If you were to work with students from three other professions, which professions would you choose first? Why?
- How is healthcare enhanced by effective teamwork between professions?

Portfolio development exercise: Advanced interprofessional self-assessment

Identify examples that might illustrate health practitioners or students behaving at one of the five Developmental Model of Intercultural Sensitivity (DMIS) levels described in Table 8.5.

- What level(s) do you believe you mostly operate at? Write these down.
- How do you think you can advance your own intercultural sensitivity as applied to the health professions? Write these down.

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USEFUL WEBSITE

National Health Priority Areas: www.aihw.gov.au/nhpa

CHAPTER 9

Learning from Failure

Eva Nemeth and Lindy McAllister

LEARNING OUTCOMES

After reading this chapter you should be able to:

- discuss difficulties you may experience as a student in fieldwork placements
- understand your experience of difficulty or failure in fieldwork placements from multiple perspectives
- be prepared to learn from failure.

KEY TERMS

Learning in fieldwork
Narrative inquiry
Perspective transformation
Readiness to learn
Transformative learning

INTRODUCTION

Learning in fieldwork placements occurs within workplace settings 'with complex interlocking arrays of people and activity' (Boud & Edwards 1999: 174). Your learning as a student on fieldwork placement can be influenced by the interplay of this complex array of variables, which include your knowledge, skills, attributes and dispositions; your capacity to manage time, tasks, yourself and others; your reflective and clinical reasoning skills; your capacity to transform theoretical knowledge into competencies required for practice; and the nature of fieldwork educator–student relationships. Given the potential for interplay between the array of variables, it is not surprising that students at times experience difficulties meeting required competencies. Such students have been variously described in the literature as being students in difficulty, marginal, borderline, strugglers, poor, inadequate, incompetent performers, at-risk or failing students (see Shapiro et al. 2002; Hicks et al. 2005; Scott Smith et al. 2007).

STUDENTS EXPERIENCING DIFFICULTIES IN THEIR FIELDWORK PLACEMENTS

Students who experience difficulties with fieldwork are a diverse group. They may present with interpersonal problems or even mental health concerns. They may have poor theoretical knowledge and/or clinical reasoning skills. Their first language and/or cultural identity may differ from the language of instruction or dominant culture of their educational or clinical practice environment. They may be older and less able to adapt to new modes of teaching and learning such as peer learning (Baldry Currens 2010); alternatively, they may be 'Generation Y' and bored with the requirement to master theory as well as engage in their preferred mode of active learning (Ryan & Hills 2010). Key characteristics of students who experience difficulties with fieldwork placements (see, for example, Hicks et al. 2005) along with examples of competencies (McAllister et al. 2006) that may be affected are summarised in Table 9.1. Although these characteristics can serve as warning signals, they do not portray the complex interactions between student characteristics and the many demands of learning in fieldwork environments.

Table 9.1: Characteristics of students experiencing difficulties and possible competencies affected

Characteristics	Competencies that may be affected
Behavioural difficulties including dishonesty, defensiveness, a lack of awareness or ownership of the problem and a lack of commitment or motivation	Professionalism; lifelong learning; communication competencies
Interpersonal problems including poor communication skills, lack of assertiveness, overassertive or demanding behaviour, lack of integrity or lack of compassion	Communication; professionalism (including ethical conduct); assessment and intervention competencies
Cognitive problems including learning difficulties (such as poor writing skills, poor organisational skills and poor memory), poor critical thinking or clinical reasoning skills, an inability to integrate knowledge, poor conceptual knowledge and understanding, poor planning and rigid thinking	Clinical reasoning; ethical reasoning; evidence-based approaches to assessment, diagnostic, intervention planning and delivery; lifelong learning
Clinical skills deficits including poor application of knowledge to fieldwork; poor diagnostic, planning or therapeutic skills	Clinical reasoning; competencies in assessment, diagnostics, intervention planning and delivery of therapy
Mental health or emotional problems including mental health problems, inability to manage anxiety and stress or depression	Communication; professionalism; lifelong learning; clinical and ethical reasoning; therapy skills
Difficulties adapting to the dominant culture including poor communication skills, inability to interpret body language, poor understanding of rules and beliefs operating within the dominant culture—all of which can affect student interactions with others and student adaptation to fieldwork settings	Communication; professionalism; clinical reasoning; assessment, planning and delivering therapy

THINK AND LINK

Chapters 3 and 5 have some practical exercises on self-reflection. Refer to Chapter 5 for the practice window, which may be helpful to you if you suspect you may have some characteristics listed in Table 9.1.

It is surprising that there is little literature available describing students' experiences of difficulty and failure in their fieldwork placements, given that those students who experience difficulties in fieldwork have an impact upon all stakeholders involved in fieldwork education: other students, fieldwork educators, clients and university programs. Understanding students' experiences of difficulties or failure may assist in better preparing and managing such students by identifying factors that have an impact on their learning and strategies that might optimise their learning.

This chapter draws on research that investigated the experiences and perspectives of students who encountered difficulties or failure in fieldwork placements (Nemeth 2008). The methodology of this study utilised a qualitative research methodology called '**narrative inquiry**' (van Manen 1990) which was integrated with a hermeneutic phenomenological approach (Connelly & Clandinin 1990). Through narrative analysis of in-depth interviews with seven students, abstractions that were common to students' experiences and those that were different among students who participated in this study were identified. It became clear that each student was talking about aspects of being 'ready to learn' from the experience of failure in the fieldwork placement (Nemeth 2008). **Readiness to learn** refers to students' readiness to use the experience of failure in a fieldwork placement as a catalyst to alter perceptions of themselves or their worldview. When such altered perceptions occur, the experience of failure in a fieldwork placement can become a transformative learning experience.

Although the research discussed in this chapter focused on speech pathology students, presentations of the research at numerous health professional development events suggest that the implications of the research have broad applicability in the preparation and support of students across the human service professions. This chapter presents data drawn from two speech pathology students' experiences, accounts and understandings of failure in their fieldwork placements. The stories reveal how one student was ready to learn from this experience of failure while the other was not. The concepts of readiness to learn and transformative learning are discussed, and suggestions are provided to support learning for students experiencing difficulties or failure and their fieldwork educators.

CASE STUDY

Chris's story of failing fieldwork

Chris was a final year speech pathology student when she experienced failure in her final paediatric fieldwork placement. Throughout the first three years of the undergraduate program, Chris experienced difficulties with academic exams and had sought assistance from the university to improve her skills in answering exam questions. Thus, at the start of her final placement, Chris had perceived herself as being less academically capable than her peers and as having strong clinical skills.

Chris felt fatigued at the start of her **final fieldwork placement** because it occurred immediately following completion of her academic exams. Chris also found it difficult to cope with the daily two-hour travel to attend the placement, and by mid-placement she felt that her skills were inadequate for her stage of learning.

> I was finding things really hard ... I knew I was having problems. You're sort of at that stage in the course you know what's expected of you ... By the way, I was crying every night because I was just so upset. I was feeling so incompetent ... That was the thing: this is really my last child placement. If I can't cope here, how am I going to cope by myself?

She attempted to improve her skills by searching for solutions, such as referring to lectures to help access her theoretical knowledge, as much as time permitted. Previously Chris's fieldwork 'had always gone well, so that's what I hung onto' as a source of strength, yet she was aware that her clinical skills and knowledge were suddenly inadequate.

> It was just awful ... I've always hung onto clinic as my strong point and academically I haven't gone so well and suddenly I wasn't going well at clinic and I thought, 'Oh, I've got nothing now'.

Chris was aware that her skills were inadequate. However, she was 'devastated' by her mid-placement assessment, which showed failure. Despite her hopes that her skills might not have been as poor as she had feared, upon seeing her results, she realised, 'Oh, this is reality; this is the truth.' Failure was not only personally confronting and challenging but resulted in her losing confidence in her abilities. Chris relinquished control of her sessions with her client 'to [my fieldwork educator] because I just felt so incompetent and I just couldn't go on'.

However, towards the end of her placement Chris became more confident to again take control of her sessions and 'have a go'.

> I didn't want to make a fool of myself. At the beginning of the placement I probably wasn't willing to answer any questions. I'd just say, 'I don't know.' At the end of the placement ... it felt better to have a go at things than to leave it unanswered.

Failure gave Chris permission to 'not know', and thus she could risk saying the wrong thing because her lack of knowledge was now exposed. Chris was also receptive to her fieldwork educator's appraisal and assessment of her clinical skills as inadequate. She did not solely deflect reasons for her difficulties to external sources, although she could acknowledge both external factors (such as her limited time availability to read relevant clinical theory) and her clinical deficiencies, which influenced her fieldwork educator's decision to fail her. Her inherent strength, insight and self-awareness meant that she was 'robust' enough to acknowledge her deficiencies, which contributed to her less than adequate performance.

Due in part to Chris's awareness of her difficulties and her receptiveness to confirmation of failure at her mid-placement evaluation, Chris became more open and honest with her fieldwork educator. This allowed her fieldwork educator to assist her in learning effectively. In fact, Chris maintained a good relationship with her fieldwork educator.

> It was weird because usually if you have a bad experience you usually sort of blame it on your clinical educator, but she was really good and ... sort of perceptive that ... I was worried about things. She was so supportive.

Chris and her fieldwork educator worked collaboratively so that Chris could improve her skills. Chris expressed anger about past fieldwork experiences and the failure of her previous fieldwork educators to prepare her for the demands on a final year student. Yet she was not angry about the circumstances in her placement, where failure actually occurred. She acknowledged that her skills were inadequate, and allowed herself to accept the unpleasant reality of this acknowledgment.

Chris's openness and receptiveness to her fieldwork educator's appraisal of her inadequate clinical performance, in conjunction with her accurate self-appraisal of her deficient clinical skills and willingness to accept that those skills were deficient, meant that she could account for failure in a fair and balanced way. Chris felt that her skills improved considerably as a result of her experience of failure.

> Like I said, you don't like to have those sorts of life experiences, but in a way it helped me realise what I needed to know, and how I needed to do it ... I can look back now and say that it was really great but at the time it was very traumatic.

QUESTIONS

1 Have you had an experience like Chris's? If so, did you have similar feelings? Why, or why not?

2 Do you think that you can learn from failure?

Interpreting Chris's story

Chris's story suggests she possessed considerable awareness of where her clinical competencies were deficient. Her insight into issues affecting her poor performance, plus her receptiveness to her fieldwork educator's feedback, meant that she was ready to learn. Her perception of having had strong clinical skills before this placement may have helped her ward off feelings of inadequacy about her poor academic results and her intelligence. However, through the experience of failure, Chris altered this perception to incorporate new information that some key competencies such as assessment, analysis and interpretation and clinical reasoning were not at the required graduate entry level. This altered perception was reintegrated, and became part of how she then perceived herself. Thus she experienced a **perspective transformation** (in her case, realising that she could no longer view herself as having strong clinical skills), which suggests that she was ready to learn from failure in a clinical placement. Once she experienced the perspective transformation, she could focus on improving her clinical skills so that she could achieve entry-level clinical competence, accepting that this required a further fieldwork placement. Failure became a catalyst for her to experience a perspective transformation.

By way of contrast to Chris's readiness to learn from her experience of failure, Rita's story provides an example of a student who was not ready to learn from her experience of failing her clinical placement.

CASE STUDY

Rita's story of failing fieldwork

Upon matriculation from school, and before enrolling in the speech pathology undergraduate program, Rita had enrolled in another degree and boarded at one of the colleges at a university campus. In comparison to previous life experiences from a country town, her newfound freedom was unprecedented. She frequently drank alcohol to excess and failed her academic subjects.

Rita decided that a career in speech pathology might suit her more. However, upon moving in with some relatives Rita felt isolated, bored and lonely. During this same period, Rita broke up with her boyfriend and began to experience more significant feelings of low mood:

> I went insane. I was very depressed. I had never been so depressed in my whole entire life, you know. It lasted about three months ... People talked to me and I just start crying. It was horrendous. I was just so depressed really just wanted to die I felt so bad ... It was awful. I was like suicidal, not suicidal because you're too apathetic to do it. Like I couldn't be bothered. You know when you're so depressed you sleep so much ... I just wanted to die.

Despite these feelings and even suicidal thoughts, Rita did not seek professional assistance to overcome her problems. Towards the latter part of the second year of her course, Rita flatted with her sister and secured a part-time job to help support herself financially. Her priorities at the time were paid work so that she did not have to rely on her parents' financial support. Consequently, she was working up to three shifts per week.

> I think when I moved out [from my relatives' place] that's when I really lost it. I started drinking and drugs and stuff.

In her final year, Rita's difficulties with her fieldwork placement came to the fore. Rita reported that her fieldwork educator felt that she had poor organisational skills and failed to prepare adequately for her sessions, which compromised professional competence and safe client care.

> My clinical educator initially said ... I am a disorganised person, which unfortunately is probably not good in speech pathology ... So I worked quite hard. Well I didn't work hard but like I made sure I was organised for her.

Rita's failure to take responsibility for adequate client management came to the fore towards the end of her placement.

> I was going to do [a particular assessment] ... And she said, 'Have you looked at the assessment?', and I said 'No', and she said, 'What! You should have [prepared the assessment]'. Like, I was really [casual] about it but she said, 'You know, you can't just go look at it and then do it'.

Rita felt that her fieldwork educator overreacted to her inadequate preparation for the assessment and 'picked on' her.

> She said ... 'I thought you'd changed ... You can't go on, if you're going to be like this.' And I was sitting there saying 'yeah yeah', and inside, saying, 'I hate you, I hate you!'

Although Rita was aware that she should have been better prepared for her assessment of a client, she felt angered by what she saw as an overreaction by her fieldwork educator. Rita did not acknowledge that her inadequate clinical preparation and inability to take responsibility for her work were the reasons she was failed at her end-placement evaluation.

QUESTION

If you had a placement with Rita, would it have been an easy placement for you? Consider whether Rita's attitude would have affected you, and whether you would have had to do Rita's work as well.

Interpreting Rita's story

Rita's story suggests that she had been receptive to listening and attempted to placate her fieldwork educator's concern that she was disorganised early on in her placement. But when she was later failed for her lack of professional behaviour, Rita showed scant regard for the seriousness of her inadequate preparation for client care. Rita displayed many of the characteristics of failing students listed in Table 9.1. Her compromised clinical competencies and failure were of little consequence to Rita, despite feeling anger towards her fieldwork educator for failing her. It is possible that her limited self-awareness and lack of insight into the need to take her clinical work seriously were also by-products of her lifestyle choices and deteriorating mental health, all of which may have had an impact upon her ability to appraise her situation in a fair and balanced manner.

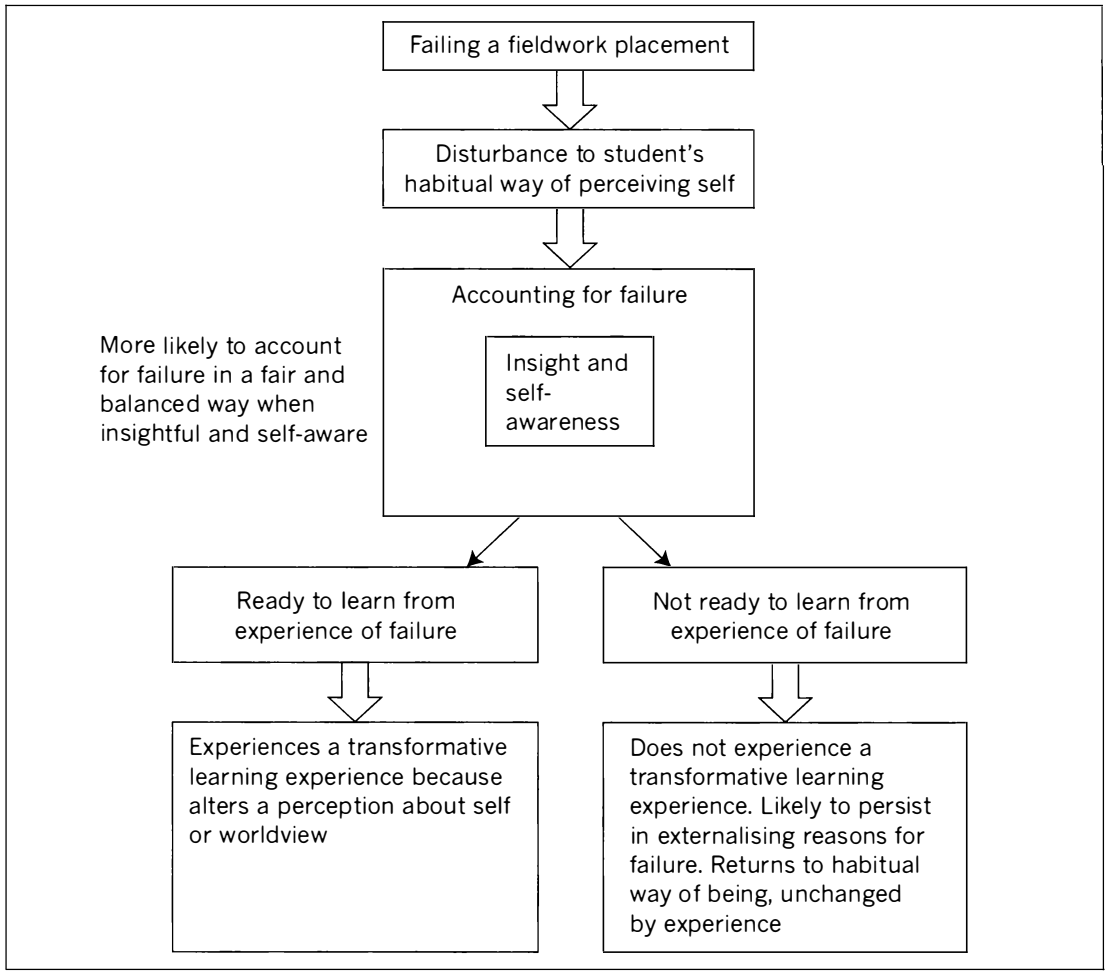
Although Rita remained angered by the experience, failure was not a catalyst for experiencing a perspective transformation. Instead, Rita returned to her habitual way of being, unchanged by the experience. She was not ready to learn, because she showed limited self-awareness and little insight into her behaviours and their consequences, and she lacked receptiveness to hearing that her skills and competence were insufficient to warrant passing. Fortunately for Rita, some time after the conclusion of her failed fieldwork placement, she sought professional help for her problems.

READINESS TO LEARN

Figure 9.1 depicts students' readiness to learn. We return to Chris's and Rita's stories to explain the diagram in terms of how a student may or may not be ready to learn from a fieldwork placement where he or she experiences difficulty or failure. Figure 9.1 depicts how failing a fieldwork placement causes disturbance to students' habitual ways of perceiving themselves.

Both stories illustrate the next stage in the diagram: how students try to make sense of their experience of failure by determining why failure has occurred. The ways in which

Figure 9.1: Readiness to learn from failure in a fieldwork placement



students account for failure, together with their insight and self-awareness, influence whether students are ready (or not) to learn from their experience of failure. Chris accounted for failure in a fair and balanced way, and was robust enough to consider that her skills were poor. Thus she could experience failure as a catalyst for a transformative learning experience, as is denoted on the left-hand side of Figure 9.1.

Rita, however, was angered by her fieldwork educator's reaction to her inadequate performance, and felt that her fieldwork educator overreacted to her lack of preparation. Rita externalised blame for her problems, and was less able than Chris to account for failure in a fair and balanced way. Furthermore, Rita's poor insight and self-awareness also influenced her lack of readiness to learn from her experience of failure.

TRANSFORMATIVE LEARNING

Wade (1998: 717) defined *transformative learning* as a 'dynamic, uniquely individualised process of expanding consciousness whereby an individual becomes critically aware of old and new self-views and chooses to integrate these views into a new self definition'.

This is compatible with Mezirow's (2000) description of a *perspective transformation* as requiring an individual to question what is being done incorrectly and correct distortions in reasoning and attitudes. According to Mezirow (1991: 14), a perspective transformation is the 'process of becoming critically aware of how and why our presuppositions have come to constrain the way we perceive, understand, and feel about our world; of reformulating these assumptions to permit a more inclusive, discriminating, permeable and integrative perspective'.

Chris experienced a perspective transformation because she reintegrated a new perception of herself that arose because of her experience of failure, which ultimately added to her self-knowledge, the importance of which has been acknowledged in clinical education (Higgs & Titchen 2000). In contrast, Rita attributed her failing largely to external factors, and returned to her habitual way of being, unchanged by her experience. Rita's mental health status and lifestyle choices appeared to have influenced her habitual way of being, her self-awareness and her insight, which seemingly compromised her readiness to learn from failure. Her experience of failure in her fieldwork placement therefore was not a catalyst for a perspective transformation. Nonetheless, when the experience of failure is transformative, as for Chris, students are more likely to be able to improve their skills by addressing their deficiencies in an authentic manner. Perhaps such individuals are more likely to function as self-directed learners because they are able to acknowledge and learn from their deficiencies. It is possible, therefore, that individuals who can experience a perspective transformation may be the types of adult learners and professionals who are proposed by authors as important for the health professions (McAllister & Lincoln 2004).

SUGGESTIONS FOR EDUCATORS AND STUDENTS EXPERIENCING DIFFICULTIES OR FAILURE IN THE FIELDWORK SETTING

The following reflections assist students and their fieldwork educators working with students experiencing difficulties or failure in fieldwork.

We have found that, even though it may seem that students have a myriad of difficulties that contribute to their failing grade, there are often one or two key issues that underpin their difficulties. For example, if it appears to be a time management difficulty, it may be that students do not know how to treat their patients because they do not have a constructive framework within which to work. With students who 'talk too much', we would explore reasons for this behaviour, such as whether students felt uncomfortable with silences, whether students felt compelled to tell patients everything they know to assert themselves as professionals, or whether they felt fearful of hearing and having to deal with their patients' feelings of loss or grief. Below we provide suggestions for fieldwork educators dealing with students who experience difficulties in fieldwork placements and for students who find themselves in this situation.

REFLECTION

SUGGESTIONS FOR STUDENTS: QUESTIONS TO ASK YOURSELF WHEN TOLD YOU ARE FAILING

- Might there be some truth in what my fieldwork educator is saying about my performance in my fieldwork placement?
- How aware am I of my own behaviour and skills generally?
- How would my peers, friends and family perceive me and my self-awareness?
- How self-aware and insightful am I about my performance in the fieldwork setting?
- How do I perceive my performance in my fieldwork placement compared with my fieldwork educator's assessment of my performance?
- How can I try to account for my difficulties in a fair and balanced way? (Speak with your fieldwork educator or others who can be frank with you about this.)
- What other resources can I utilise to assist my learning?
- Are there any other career choices that might suit me better?

REFLECTION

REFLECTION FOR STUDENTS WITH DIFFICULTIES IN FIELDWORK

- Reflect upon what aspects of your own knowledge, behaviours, attitudes, learning abilities, emotional and stress issues, mental health or adaptation to the dominant culture may be contributing towards difficulties.
- Acknowledge that having difficulties in a fieldwork placement can be a highly charged and emotional event, and that it is a normal reaction to try to determine or even agonise over why difficulties have occurred.
- Discuss with your fieldwork educator your perceptions of why you are having difficulties, while considering the possible accuracy of your fieldwork educator's perceptions.
- Use other students, fieldwork educators or university staff to gain alternative perspectives if your relationship with your educator is problematic.
- View the experience as an opportunity for self-growth.
- Consider how you can use the experience as a catalyst for a transformative learning experience.

REFLECTION

SUGGESTIONS FOR EDUCATORS: PROMPTING EDUCATORS' REFLECTIONS ON THEIR STUDENTS' READINESS TO LEARN

- Was the student ready to learn from his or her experience?
- If so, what did the student learn? If not, reflect upon the reasons that person might not have been able to learn from their experience.
- Did the student experience a change in perception?
- If so, did you assist in facilitating that changing perception? How?

THINK AND LINK

Chapter 6 discusses assessment from the student's perspective. Refer to Chapter 6 for more information on how you can be more aware of assessment criteria and how to address the assessment process.

SUMMARY

This chapter suggests that an important consideration for students who experience failure is to consider their readiness to learn from the experience. Failure could be seen as a detour that provides opportunities for transformative learning experiences that ultimately increase student self-knowledge and readiness to learn. Gaining students' perspectives about their experiences of struggling or failing in placements could well assist students in becoming ready to learn from their difficult placements. In addition, do not underestimate the importance of fieldwork educators considering their own behaviours, expectations and interaction styles that may be contributing to a difficult placement for a student.

Discussion questions

1 What might I ask my fieldwork educators in all my placements to ensure that I am learning and developing the required competency levels?

2 What competencies does my health profession demand of me for my final fieldwork placement?

3 Would I be ready to learn if faced with failure on a fieldwork placement?

Portfolio development exercise: Diagnosing problems in fieldwork education

The following points are given for you to consider as they may assist you in pinpointing where the issues are if you are encountering problems in your fieldwork placement.

› Work with your fieldwork educator to understand your difficulties: try to get to the heart of the issue.

› Diagnose the key areas that need to be targeted to assist you as a student to develop the required competencies most efficiently.

› Consider your awareness and ability to account for your difficulties and failure as a learner in a fair and balanced way.

› Ensure that your expectations and those of your fieldwork educator are reasonable, realistic and explicitly stated.

› Reflect on whether the difficulty is your problem or that of the fieldwork educator.

Portfolio development exercise: Managing the problems in fieldwork education

If you are experiencing problems in your fieldwork placement, the following points might assist you in some strategies to improve your coping.

- Ask your fieldwork educator to alert you as soon as possible to their concerns and perceptions of your difficulties, indicating whether they may not pass you on your placement.
- Air your concerns sensitively to your fieldwork educator and ask them to reciprocate in the same manner.
- Encourage your fieldwork educator to be open and honest about your difficulties, yet empathic, to ensure that an effective educator–student relationship is maintained.
- Work with them to develop and implement structured strategies to help ameliorate your difficulties.
- Be ready to listen to their perspectives of why they feel you are experiencing failure, as well as share your perspectives
- Be prepared to alter perceptions about yourself from what educators tell you.

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CHAPTER 10

Using Digital Technology for Knowledge Transfer

Anita Hamilton and Merrolee Penman

LEARNING OUTCOMES

After reading this chapter you should be able to:

- describe key digital technology tools that support information management and knowledge transfer
- understand how to search, store and share information using online technology
- know the importance of creating and maintaining a professional online identity
- know how to verify online information.

KEY TERMS

Digital literacy	Information management	Online technology
Digital technology	Knowledge transfer	Social media
Information literacy	Online identity	Web 2.0

INTRODUCTION

It is well established that the internet has changed how we interact as individuals and groups online across the globe (Zhao 2006; Kietzmann et al. 2012). **Online technology** has not only impacted on people in their personal lives, it has affected how professionals interact and learn with each other; the internet is now used by digitally literate people for **information management** and **knowledge transfer**. This evolution was the result of changes to the early internet, Web 1.0, which was developed as a repository for information storage and retrieval which has now become a multi-directional virtual environment, where people can interact with each other, build networks, collaborate, form questions, share information and create communities around topics of shared interest. This change was brought about by the emergence of **Web 2.0** technology, which is also described by the term '**social media**'.

Web 2.0 represented the shift towards online technologies being interactive, not static. O'Reilly (2007), considered to be the father of Web 2.0, states that the success of Web 2.0 lies in the fact that it has provided tools that have embraced the power of the internet to harness collective intelligence.

Healthcare practitioners were slower than other sectors such as business, education and politics to adopt online technology as a means of seeking and sharing knowledge for practice (Kamel Boulos & Wheeler 2007; McLean et al. 2007; Seeman 2008). The reasons for this appear to be linked with beliefs and systems already in place when these technologies became available and include:

- the healthcare workplace culture that values 'clinical contact and occasions of service' (McCluskey & Cusick 2002: 66) in preference to time spent on professional development
- ongoing professional development being seen as a personal responsibility (Jantzen 2008)
- health professionals having limited access to the internet at work (Schaper & Pervan 2007)
- the concern by healthcare practitioners about issues of confidentiality, professionalism and self-protection (Baerlocher & Detsky 2008).

The trend towards using digital technology for knowledge transfer has started to shift in healthcare and in this chapter we will give examples of how healthcare practitioners are using digital technology for information management and knowledge transfer for networking and professional development.

The internet has become a virtual space for information management and knowledge transfer beyond traditional classroom and textbook methods for education and professional development. Digital technology has demonstrated that it has the capacity to connect individuals, such as students, practitioners, researchers and the public across the globe, with research evidence and with each other. Although healthcare is still behind other sectors in adopting digital technology tools for practice, best practice models are emerging (Kamel Boulos & Wheeler 2007; Seeman 2008). Early adopters of digital technology across health professions have identified the importance of using technology in healthcare education and practice, advocating for the use of tools such as wikis, blogs, podcasts and social networking sites, created for and by healthcare practitioners (Kamel Boulos & Wheeler 2007; McLean et al. 2007; Hollis et al. 2010).

INFORMATION LITERACY

Information literacy is an essential skill for life in the twenty-first century. Students are faced with a plethora of information through their studies, in fieldwork, in the workplace and in their daily lives. Information is available through community resources, special interest groups, industry and service providers, media, libraries and the internet. Much of the information we access in day-to-day life comes unfiltered and in graphical, aural and textual modes (Bundy 2004: 3). Therefore we need to organise and store information for future access to be able to share, discuss, understand and apply information as knowledge for practice.

According to the Australian and New Zealand Institute for Information Literacy (Bundy 2004: 3), information literate people:

- recognise a need for information
- determine the extent of information needed
- access information efficiently
- critically evaluate information and its sources
- classify, store, manipulate and redraft information collected or generated
- incorporate selected information into their knowledge base
- use information effectively to learn, create new knowledge, solve problems and make decisions.

Having defined information literacy, it is important to understand the separate yet related concept of digital literacy.

DIGITAL LITERACY

Digital literacy represents a person's ability to perform tasks that include reading and interpreting media (text, sound, images), understanding and reproducing data and images through digital manipulation, interacting with others using language appropriate to the media, and evaluating and applying new knowledge gained from digital or online environments, using a computer (Hamilton n.d., adapted from Jones-Kavalier & Flannigan 2006: 9).

Information management (IM) and knowledge transfer (KT) occur within and between individuals in both real and virtual environments. Digital literacy enhances one's capacity to discover, organise and share information in the digital era, thus impacting on one's capacity to become more information literate and develop knowledge for practice. Therefore digital literacy is an essential skill for health professionals (Hamilton n.d.).

ONLINE IDENTITY

When students commence their studies to become healthcare professionals they are given information and feedback on appropriate ways to behave in the work environment. Despite students from the Millennial or Generation Y having well-developed online social networks and profiles (Junco & Cole-Avent 2008), there has been little consideration given to developing a professional identity in the online environment. It has therefore become very important to help students to become aware that how they portray themselves online will affect them in their future work environment, as everything that is posted on the internet is permanently archived.

Recently education programs and professional associations have become more aware of monitoring how their professionals portray themselves in the online environment as there are clear concerns around confidentiality, professionalism and self-protection (Baerlocher & Detsky 2008; Kashani et al. 2010). Some research suggests that Generation Y students may be less professional in their presentation and this group of students needs more education about differences between communication in their personal lives compared with communicating in the professional environment (Hills et al. 2011).

It is clear that digital technologies have blurred the boundaries between personal and professional lives, and therefore it is essential to start managing your **online profile** while you are a student. DiMicco and Millen's (2007) research indicates people who are aware that both professional colleagues and old friends will be viewing their online profiles managed their self-presentation better than those who were using social media for 're-living the college days'. With an increasing number of employers now using the internet to research job applicants, we recommend that you take some time to develop a strong professional online profile. This entails developing a profile that you are confident could be viewed by future employers, clients and colleagues as opposed to your close friends. We also suggest that you continue to monitor who tags you in photos and what is said about you in the online environment.

RELIABILITY OF ONLINE INFORMATION

As a student in fieldwork you may find it difficult to access your usual sources of information, such as your educational institution's library resources, educators or your peers. You may therefore need to access online resources using the internet and bring these to the practice setting. Scepticism is healthy, and all consumers of online healthcare information and evidence need to consider the reliability of the information they plan to use. Concerns exist around **digital technology** tools that enable anyone to be the author, such as wikis and blogs, and therefore guidelines for ethical development of online healthcare resources have been created (Letendre 2008). These guidelines include the Healthcare Blogger Code of Ethics (Figure 10.1) and the Health on the Net Code of Conduct (HONcode) (Figure 10.2).

Figure 10.1: Healthcare Blogger Code of Ethics symbol

In order to check if a blog, podcast or wiki is reliable and trustworthy, it is important to identify who created the blog and what their credentials or experiences are. Do they cite peer-reviewed sources of information, and do they display the HONcode logo. If you use information from one of these sources, ensure that they have cited their sources, and if you can, source these for use in your own learning. If there are no references, use information from blogs, podcasts or wikis judiciously, understanding that it is one person's or group's opinion, and not peer-reviewed in the formal sense. That said, rigorous debate is occurring among supporters of online technology, who state that blogs and wikis that encourage comments or are open to user input are in fact using an informal peer-review process.

Figure 10.2: HONcode symbol

DIGITAL TOOLS TO ENHANCE INFORMATION LITERACY

Knowing about a range of digital technology tools is helpful when deciding which is the best tool to meet your needs. Here we will explore several key digital tools, in table 10.1 we explore these and several other digital technology tools under the following categories of:

Content publishing tools: tools that assist us to present information so that it is appealing to others.

Content management tools: tools that assist us to seek, organise, and store information so that it is retrievable.

Networking tools: tools that facilitate discussion and help build connections between people with shared interests.

Communication tools: tools that assist us to communicate directly with others in real time or in delayed time.

Content publishing tools

Blogs

Blogs (weblogs) are websites that individuals known as bloggers create and maintain (Junco & Cole-Avent 2008). Blogs are often used as a content publishing tool as they are usually about a single topic or theme. Items are posted on a regular basis, with the most recent entries appearing at the top. Each entry is called a post, with most bloggers allowing others to respond by posting comments. Blogs can be developed and maintained by individuals or groups, even with little technical ability, and can be either private (with the blogger deciding who can view his or her blog) or public (open for viewing by anyone with internet access), or a combination of both private and public posts. A blog can include text, pictures, video, audio, internet links and RSS feeds, and the list grows as technology advances.

A growing number of health professionals maintain a professional blog. Many report that through their blogs they are discovering other people with similar interests, and have formed international online communities of practice (Kamel Boulos & Wheeler 2007; Bodell et al. 2009). This trend has also occurred among blogs created by people living with impairments or limitations, where people share stories and offer support to others experiencing a similar life event. Blogs such as these offer us an opportunity to gain insight into others' experiences and to ask questions.

As a reflective student, you may find that a blog can provide you with a forum to record thoughts, experiences, impressions and struggles. While blogs can be valuable tools, students and health professionals should be careful about the content of their reflections. If confidential information is recorded, then blog settings must be set to private, or shared only with your fieldwork educator. If the blogger chooses an open (publicly accessible) blog, then confidential or identifying information cannot be used. Open blogs are best if they focus on the individual's learning rather than experiences of the clients or the fieldwork agency.

We recommend two blogging sites: Blogger for its simplicity, and WordPress for its sophistication and adaptability.

› Blogger, owned by Google, can be set up in about 10 minutes. It has a range of basic templates, from which you can add text, pictures, video, audio, internet links and

RSS feeds (see below for an explanation of RSS feeds). You can create a personalised URL and set your blog to be public or private.

› In WordPress you can also add text, pictures, video, audio, internet links and RSS feeds, but this program offers a wider range of templates, and has the capacity for you to upload documents such as PowerPoint or portable document format (pdf) files. A key feature is that each post in a WordPress blog can be set at a different level of privacy. These can be private posts, accessed only by the blogger, posts accessible to selected people using a password, or posts that are fully open to the public. WordPress can be used to create an e-portfolio, including text, presentations, audio, video and images. You can also create a personalised URL for your site.

THINK AND LINK

Chapters 3 and 5 provide students with a 'hands on' way to understand how to be reflective in practice. Read these chapters to provide insight into reflecting on using technology as part of your fieldwork placement experience.

CASE STUDY

Meg the blogger

Meg became a blogger to record her experiences during her gap year before starting university. After starting at university, Meg was surprised that few students had blogs, and was concerned when one of the academic staff told students not to cite blogs, Wikipedia or any other non-peer-reviewed information in their academic work. Meg thought that blogging probably did not have a place in university life.

Sometime later, Meg was undertaking fieldwork away from home and she was finding it challenging. Meg thought to discuss her feelings with her supervisor, but was anxious that she would be perceived as being ill-equipped for her future profession. Meg felt isolated.

Remembering the value of her blog, Meg decided to start blogging again. She wanted to record her thoughts and feelings, so she set up a private blog in WordPress. Meg followed the guidelines for reflective journals, using pseudonyms for clients, supervisors and her location. Meg made sure that she logged out from her blogging program each time she left the computer. Her password was also a difficult one to guess being a combination of letters, numbers and symbols.

Meg incorporated a range of applications, such as text and graphics, and audio using a built-in recording application on her mobile phone, she uploaded these audio files to her blog. Meg found a mind-mapping tool online, and used this to reflect on her practice dilemmas. The mind maps were uploaded to her blog as pdf files, and she used them for ongoing reflection and to track her learning. Meg also wrote a daily journal using a digital program called 'Oh Life', where she documented issues from both her personal and student life. Sometimes Meg copied and pasted journal posts relevant to her learning into her blog so she could create links with mind maps, audio files and graphics.

One day Meg's fieldwork educator showed her a professional portfolio that she had developed over her career. It was a collection of documents, photos and certificates detailing her professional development and career highlights. Her supervisor mentioned that she also wrote in a journal to reflect on practice dilemmas.

Meg could see the parallel, and realised that she had been creating a multimedia electronic portfolio. Meg mentioned her blog and her online journal to her fieldwork educator, and offered to show her the blog. The next day Meg adjusted her settings in her WordPress blog, and allowed her fieldwork educator to access a specific post that illustrated her learning during the fieldwork placement.

The fieldwork educator said that the blog had provided her with new insight into how a student might feel during fieldwork, and asked Meg if she felt comfortable sharing this with the other members of the team, which Meg did. Meg left fieldwork strengthened in her resolve to continue to add to her blog and redirect it towards being an e-portfolio tool for the next phase of her learning, building a strong path for lifelong professional development.

QUESTIONS

1 Do you keep an online journal or blog?

2 Do you think that keeping a blog throughout fieldwork would work for you?

3 What other technology(ies) could you use to support reflection and learning?

Wikis

Wiki, which means 'hurry' in the Hawaiian language (McLean et al. 2007), is another example of a content publishing tool; however, it also fits in the category of content management as wikis facilitate collaborative writing. A wiki is a collection of linked web pages that are able to be contributed to, edited or updated by their users (Kamel Boulos & Wheeler 2007). Like collaborative writing tools, wikis can have different levels of access, such as reader, writer, editor or administrator. A wiki does not show edits to the document as they are incorporated into the whole site. Changes are only evident when you view the 'history' of the wiki. The history can also be used to 'roll back' to previous versions of the wiki, which is useful if an unwanted change has been made.

Wikis can incorporate text, pictures, video, audio, links to their own wiki pages, internet links and RSS feeds; the list grows as technology advances. Two wiki programs are recommended here:

- PBWorks is a hosted program that is free to register to use. It is one of the simplest wiki programs to use, and can be quickly set up and easily personalised. To learn how to set up your own wiki, visit its website and click on the link to the user manual.
- MediaWiki is the wiki program used by Wikipedia. It is free to download but it needs to be hosted on a computer server. This program requires some computer technical knowledge to set up and manage. If you are in a setting that has its own IT department, you can ask members of the department to download and manage MediaWiki for your project.

The best-known wiki is Wikipedia, the online encyclopaedia. It is an open wiki, which means it can be modified by anyone. Wikipedia is sometimes criticised as being unreliable; however, a comparison made with the online Encyclopaedia Britannica showed the accuracy to be very similar (Giles 2005, as cited in McLean et al. 2007: 175).

Wikis are useful for tasks that require collaboration by a group of people; for example, a group project or development of a community resource. A well-developed wiki will look and function like a website for visitors to the site and is a simple way to create digital resources for client populations. Get a Note From your Doctor is an example of a peer-reviewed wiki that is expert moderated, with only approved physicians able to post (Seeman 2008).

Podcasts

Podcasts are a content publishing tool that grew in popularity, largely after the advent of portable MP3 players, because of their capacity to capture and share class lectures in higher education settings (Hendron 2008). The name 'podcast' evolved from the use of Apple iPods; they are downloadable audio or video files. Keeping up to date with healthcare information has become easier since podcasting began, as you can download audio and video podcasts on topics of interest. To subscribe to podcasts, there is free software through iTunes. To locate podcasts, CNET Podcast Central and Podcast.com are currently two popular web-based podcast listing services. Sites like MedReader specifically focus on healthcare information, and also include podcasts. YouTube, which is the largest resource for video podcasts, includes healthcare information by both qualified practitioners and the general public.

Podcasting is becoming an increasingly popular way to share information with people who have difficulty with text. To learn how to create your own podcast visit How to Podcast, which offers step-by-step instructions on how to create your own podcast and upload it to the internet. An example of a healthcare podcast is the American Occupational Therapy Association's podcast series 'Living Life to its Fullest'.

Content management tools

Collaborative writing

Collaborative writing tools are often used as a content management tool as they are an excellent way to work remotely on a paper or project with others (Vallance et al. 2010). A number of collaborative writing tools exist, such as Zoho Writer and Google Drive. As each document is web-based, and has its unique URL, groups of people can work on a document, spreadsheet, drawing, form, table or presentation, and this overcomes the need to keep track of different versions. Once completed, the final version can be uploaded back to the relevant program such as Word, PowerPoint or Excel. These tools are appealing to healthcare workers, as they can be used to organise meetings, take notes or create joint documents, which enables people to work smarter and more efficiently.

In fieldwork, collaborative writing tools could be used as part of a student's reflective learning cycle, with the student completing an online reflective journal and the supervisor adding comments to aid reflection. Similarly, groups of students could collaborate to complete fieldwork assignments or to create documents, such as information pamphlets, for their fieldwork facility.

Credibility of information in a collaborative document lies with the authors, who are known to each other. Reliability of the collaborative writing tools can be a concern if the company running the program decides to remove it from the internet. Users of collaborative writing tools are recommended to back up their work to a reliable place, such as their own hard drive, a pen drive or another cloud drive (for example, Dropbox). Students should also be aware that computer hackers may access their documents, just as they do hard drives of computers. Therefore, while the companies developing the software assure the user that they are doing their utmost to ensure privacy, students need to consider the type of information they store in collaborative programs, and always pay careful attention to the potential that it could be accessed by others.

Cloud drives

Cloud drives are content management tools that provide digital storage space on a remote server and can be accessed using the internet. Dropbox is a popular cloud drive that offers a limited amount of online storage space for free and additional storage space for a monthly or yearly fee or when you invite others to join. When you are on fieldwork, cloud drives make it possible for you to store and sync documents and other electronic media, meaning that as long as you have internet access you can access documents that you placed in your cloud drive.

Cloud drives are different from collaborative writing tools as files cannot be opened and updated synchronously. If files are opened at the same time by different users a second version of the document will be created, which can cause confusion. If you need to work collaboratively and synchronously on a project use a collaborative writing tool such as Google Drive or Zoho writer.

Syndication feeds (RSS)

'RSS' stands for 'Really Simple Syndication', 'Rich Site Summary' or 'RDF Site Summary' (McLean et al. 2007). RSS is a content management tool which allows you to subscribe to alerts from internet news services, blog or podcast updates, journal table of contents alerts and database searches such as in Pubmed. Subscribing to RSS feeds means that you don't have to regularly check your favourite websites or blogs for updates; rather you are informed of updates. It is simple to subscribe to any site that has the RSS symbol (Figure 10.3)—go online to Commoncraft (see Useful Websites at the end of this chapter).

To start receiving RSS feeds, you will need to set up a reader or an aggregator to receive subscribed updates. We suggest using either Google Reader or Bloglines. Bloglines offers you the opportunity to search other feeds or blogs using keywords, and Google Reader offers you the option to share your RSS feeds with others, thus enhancing everyone's access to online information. You can also get apps for readers on iPhones, iPads and android phones.

Networking and communication tools

Online social network sites are networking tools that support the maintenance of existing social networks, or help people connect with people from around the world who share interests. Sites can vary in the types of applications and communication tools they offer users, such as mobile connectivity, blogging and photo- or videosharing (Kamel Boulos &

Wheeler 2007). The most important features of social network sites are that they display social connections and give information about identity. There are more than forty major social network sites on the internet but here we will compare two key social network sites, Facebook and LinkedIn.

Facebook is the largest social networking site in the world and allows members to create an individual profile, form groups around a special interest or develop a page to disseminate information about a person, group or product (Kashani et al. 2010). Using online social networking sites opens up the possibility of making new connections. However, it also opens you up to having your information shared on the internet without your knowledge. Facebook users can increase the likelihood that their information is only shared with individuals whom they choose by maintaining tight privacy settings and keeping up to date with changes to Facebook policies (Kashani et al. 2010).

LinkedIn is a social networking tool designed to meet different objectives than Facebook. LinkedIn was set up as a business networking tool, not a social networking tool, and was designed for users to input information about their professional identity. It has strict rules about how one can connect with others, for example when a LinkedIn user tries to connect with another user, the program asks them how they know this person before it lets them connect. Often you will need to know the email address of the person you are wishing to connect with. LinkedIn is designed for users to connect with people they already know, or to create links between people who have mutual connections. LinkedIn is an online space to develop a professional profile, where you can upload your resume and resources you have developed, include testimonials and join professional discussion groups on topics of your choice. LinkedIn also provides the option to create groups around shared interests.

REFLECTION

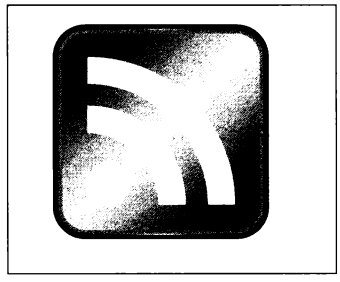
USING SOCIAL MEDIA

1 Do you use social media in your personal life?
2 What could you do to strengthen your professional identity using social media?

Virtual worlds

Multi-user virtual worlds can be categorised as networking tools, communication tools and content publishing tools. They are computer-based, simulated multimedia environments that are designed to enable users to build information repositories and interact with each other in an online environment. Each user has a customisable graphical self-representation known as an avatar, which has its own name and can be adapted to have unique features (Kamel Boulos & Wheeler 2007). Currently the most popular virtual world is Second Life, with 8.9 million residents in 2008 (Seeman 2008). Second Life is an example of the emerging world of Web 3.0,

Figure 10.3: RSS symbol



a 3-D social network, where people collaboratively create and edit objects and interact in a virtual world.

Second Life is evolving rapidly, and Kamel Boulos and colleagues (2007) identified the following capabilities that are applicable to healthcare education and practice:

- multimedia content, such as audio, video or TV collections
- information spaces: document collections in 3-D virtual libraries
- new places and cultures
- multiplayer games, including educational, health-related games
- virtual and real-life goods and services
- healthcare information and skill development
- interaction and networking with other people and communities
- attendance at and participation in lectures, conferences, festivals and concerts.

Healthcare education initiatives are growing in number in Second Life, with Healthinfo Island being the biggest healthcare initiative so far. In 2009 it was reported that there were over 200 groups on Second Life providing consumer health information and general health education resources (SLHealthy 2009, as cited by Chan 2012).

Table 10.1 presents a summary of digital technology tools that can help you manage information and create knowledge for practice. Each of the digital tools listed could be used in more than one functional area (e.g. blogs can be used for content management and content sharing), so each tool is listed under the functional area of the tool's strengths.

Table 10.1: Digital technology tools: Function and application in fieldwork

Function	Tools	Description	Application
Content management	Collaborative writing (e.g. GoogleDrive™, Zoho Writer®)	An online program that stores documents created by one or more people in a cloud drive. Facilitates editing and reviewing of a document by multiple individuals, either synchronously or asynchronously.	Complete a project with another student. See example: https://drive.google.com/start#home or www.zoho.com
	Personalised home page for web browsing (e.g. Netvibes)	An online page that uses widgets and gadgets to assemble social networks, email, calendar, videos and blogs etc. on one customisable home page. RSS feeds (programs that push information to your computer) enable automatic updates.	Create a personalised home page with resources that meet your needs for fieldwork. Include a calendar, sticky notes, weather and news. Subscribe to RSS feeds on topics related to the setting. This is a private site, available only to you.
	Scholarly Databases (e.g. Pubmed™, Google Scholar)	A freely accessible web search engine that indexes the full text of scholarly literature across an array of publishing formats and disciplines.	Research evidence relevant to the fieldwork setting. Create alerts to be updated on new articles relevant to your setting. Conduct a 'journal club' using the outcomes of your findings.

Function	Tools	Description	Application
Content management	Bookmarking: Social bookmarking (e.g. Diigo, Delicious™)	A tool to bookmark (save) web URLs in a virtual/ online environment rather than on an individual computer. The user's account can be public, semi-public or private. You can store a range of useful websites, comment on them, categorise them using tags, and share.	Save and tag websites under topic headings and share with peers, fieldwork educator and clients. See examples: http://groups.diigo.com/index or http://delicious.com
	Cloud Drives (e.g. Dropbox)	Cloud drives are content management tools that provide digital storage space on a remote server and can be accessed using the internet.	Store learning materials from university in a cloud drive so that you can access information while out on fieldwork. See example: www.dropbox.com/
Content publishing	Blog/ Weblog (e.g. Blogger™, Wordpress™)	A website where items are posted on a regular basis with the most recent posts at the top. Usually a blog is about a single topic or theme; they can be reflective and/or educational.	Create a site about your area of expertise as a knowledge translation tool. See example: http://healthskills.wordpress.com
	Wiki (e.g. Wikipedia, Ask Dr Wiki)	A wiki is an interactive web page designed to enable anyone who is allowed access the ability to contribute or modify content.	Create a resource for clients about a specific topic. See example: http://askdrwiki.com/mediawiki/index.php?title=Physician_Medical_Wiki
	Microblog (e.g. Twitter)	An online program where users can submit text, hyperlinks, video or pictures. Text entries are restricted to 140 characters.	Create a professional Twitter account and share news stories about your area of practice or your profession. Or follow tweets from those attending an occupational therapy conference. See example: http://otalkocchats.wordpress.com/otalkocchat-topics-2011-2012

(continued)

Function	Tools	Description	Application
Content publishing	Curation services (e.g. Storify, Scoopit, paper.li)	Curation services are programs that collect and organise topics of interest. They facilitate creation of theme-based digital publications (e.g. newsletters).	Create a digital newsletter with your client group using a program like paper.li or Storify. See example: http://tinyurl.com/otdaily
	Virtual pinboard (e.g. Pinterest)	A content sharing service that allows members to 'pin' images, videos and other objects to their online/virtual pinboard.	Create a pinboard about a topic of shared interest and teach others how to contribute. See example: http://pinterest.com/otinmh/expressive-creative-media-in-ot-ideas
	Virtual presentation (e.g. Slideshare, Prezi)	A platform for business documents, videos and presentations. Anyone can share presentations and video and both allow for users to find relevant content and connect with other members who share similar interests.	Create a series of informative presentations for your client group, or share what you have learnt. See example: www.slideshare.net/baotcot/twitter-twaddle-4822006
	Podcast/ video cast (e.g. YouTube™ iTunes™)	A series of audio or video digital-media files that is distributed over the internet by syndicated download (RSS), through web feeds, to portable media players and personal computers. NB: users can download from or upload to YouTube, iTunes etc.	Create an educational video or podcast. See example: www.aota.org/consumerpodcasts
Communication	Voice over Internet Protocol (VoIP) (e.g. Skype™, Elluminate)	Enables users to talk in real time using the internet. Can be audio, video or both. Can be recorded and replayed using supplemental computer programs.	Having access to this technology can enable clients to remain socially connected and interact with healthcare professionals remotely.
	Survey tools (e.g. SurveyMonkey™, Fluidsurveys)	An online survey system to deliver surveys, collect and analyse results through one central system. Many also include interpretive graphics and charts.	Online surveys are an excellent way to explore clients' needs, and evaluate effectiveness of services. See example: www.surveymonkey.com

Function	Tools	Description	Application
Networking	Social networking sites (e.g. Facebook™, LinkedIn)	Online communities of people who share interests and activities, or who are interested in exploring the interests and activities of others.	Join or create a LinkedIn or Facebook discussion group about your area of practice to help you connect with other students around the globe.
	Discussion forums (e.g. phpBB™)	An online discussion space for people to interact with others who share a specific interest. Unlike online chats in which participants communicate synchronously, most discussion forums are asynchronous.	Find or create a discussion forum for your client population to discuss topics of shared interest. Note, students should visit the site and check the reliability of the information before recommending a client uses it for support. See example: www.healthboards.com
	Multi-user Virtual World (e.g. Second Life®)	A virtual world where the user is represented by an avatar in a 3-D virtual environment. Users can interact with each other. Information can be presented using text, audio and video.	Facilitate a client to join a virtual support group. See example: http://secondlife.com/destination/28

Source: Adapted from Hamilton (n.d.)

SUMMARY

With the explosion of new ways to discover, organise, create and share information, skills in digital literacy have become another essential skill for healthcare professionals. According to Hinojosa (2007: 629) 'we are living in a time of hyperchange' and the speed at which knowledge becomes obsolete is between two and five years. This means that 90 per cent of what we know today will be irrelevant in five years time (Lynch 2000, as cited in Hinojosa 2007: 630). Digital technologies, particularly interactive social media, have changed the ways we can manage information and create new knowledge to improve practice. Digital technologies have created a virtual environment where health professionals can discover, organise and process information so that they can create knowledge that can be applied in context of practice.

Health professionals, not just students, are continually reminded that there is new information for practice that they need to access and critically appraise. This situation is magnified by the fact that health professionals need to cope with ever-changing health service demands. With the speed of change, information in texts and journals can quickly become outdated; therefore, use of digital technology to access online resources has become vital.

Digital technologies are not a fad (Seeman 2008); therefore, knowing how to effectively use these tools to optimise learning is crucial to building capacity by healthcare professionals for information management and knowledge transfer now and in the future.

Discussion questions

1 What steps can you take to ensure that the online healthcare information you access is credible and trustworthy?

2 What issues do you need to consider if you were to blog about your experiences with a challenging client or fieldwork setting?

3 Which digital tools could you utilise more effectively for information management and knowledge transfer?

Portfolio development exercise: Online profile development

This exercise is designed to be completed several weeks prior to going out on placement and should also be updated regularly. List all the social media tools you currently use in your personal and student life. There are likely to be several such as Facebook, Twitter, YouTube and others.

1 What names do you use when you work online using digital technology? Are they searchable using your full name?
   a Tip: You can change your online name to protect your identity for personal information.

2 Do you have privacy settings set to the most private level?
   a Tip: You can set very high privacy settings for tools such as Facebook but lower settings in a professional tool such as LinkedIn.

3 Do you provide information online that is sensitive from a professional perspective and, if so, could this place you in an ethical dilemma with your professional association?
   a Tip: Writing about your fieldwork experiences and giving information about a client or a setting that is potentially identifiable is not ethical.
   b Tip: Being tagged in photos that give away information about your personal life can negatively impact on trust in you as a professional (for example, photos of you at a party). Keep an eye out for these and un-tag yourself from photos that are not professional where your name is used.

4 Are you using social media to make a positive impact on or for your profession?
   a Tip: Create a Twitter account with a professional name and start to share resources as a professional with others in your profession.
   b Tip: Create or join an online discussion forum in Facebook to discuss professional issues or create opportunities for networking and professional development. Note: these pages should not be a place to give advice to the public.
   c Tip: Join LinkedIn and upload your resume and connect with others in your field.

5 Have you used social media such as YouTube or Slideshare to capture your growing portfolio of skills?
   a Tip: Upload impressive posters and assignments to Slideshare; upload exemplar digital objects to YouTube and then link all to your electronic portfolio (an electronic portfolio mimics a paper portfolio—it can be stored in the online environment in a program such as a free WordPress blog).

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USEFUL WEBSITES

Blogger: www.blogger.com

Bloglines: www.bloglines.com

CNET Podcast Central: www.cnet.com/podcasts

Commoncraft: www.commoncraft.com

Facebook: http://facebook.com

HONcode: www.hon.ch/index.html

How to Create a Podcast: www.how-to-podcast-tutorial.com

Mashable: http://mashable.com

MediaWiki: www.mediawiki.org/wiki/MediaWiki

MedReader: www.medreader.com

PB Works: http://pbworks.com

Podcast.com: http://podcast.com

RSS in Plain English: www.commoncraft.com/video/rss

Second Life: http://secondlife.com

WebCite (healthcare blogger code of ethics): www.webcitation.org/5aDEkONrK

WordPress: http://wordpress.org

CHAPTER 11

Fostering Partnerships with Action

Michelle Courtney and Jane Maidment

LEARNING OUTCOMES

After reading this chapter you should be able to:

- understand students' engagement with partnerships in fieldwork education from a critical perspective
- understand the role of key stakeholders in fieldwork education
- understand the importance of fieldwork partnerships
- discuss students' roles in fieldwork partnerships.

KEY TERMS

Core business
Forcefield analysis
Government
Horizontal partnerships
Individual professional
Integrated fieldwork practice
Profession
Stakeholders
Triple helix partnering model
University
Vertical partnerships

INTRODUCTION

There is a growing body of literature acknowledging the significant professional and pedagogical drivers for **integrated fieldwork practice** (Courtney 2008; Beddoe & Maidment 2009). You were aware of the requirement for fieldwork placement when you signed up for your studies as a health and human services professional. You will now have a clear understanding of the specific requirements for fieldwork placement as they are listed in your course handbook. You will fulfil these specific requirements within the day-to-day real world of health and human services. The real-world dynamics of fieldwork placement are

complex. It's important for you to have some understanding of these dynamics to function positively during your fieldwork placement.

The aim of this chapter is to provide a practical introduction to the day-to-day dynamics of fieldwork placement in the health and human services. We will be taking a big-picture view of fieldwork placement. We will discuss who's who in fieldwork, and why it's important that we all work together positively, including you in your role as a consumer of fieldwork education.

We begin this chapter discussing the key stakeholders in fieldwork placement: the profession; the university; the government; the individual professional; and you, the student. Using a broad-brush approach, we will introduce some important aspects of the perspective of each of the stakeholders. We will discuss why partnerships matter in placements and conclude with the important role that you play in fieldwork placement partnerships.

KEY STAKEHOLDERS

Although there are differences between each health and human service profession, they have in common fieldwork placement as a requirement of qualifying studies. The key *stakeholders* involved in fieldwork placement consistently support the advantages of work-integrated learning. Stakeholders creatively, positively and consistently explore ways to optimise the provision of fieldwork placement in the day-to-day real world of health and human services. Nevertheless, given that placement is not the **core business** of any of the key stakeholders, these groups do not see fieldwork placement from a common perspective. It's important to begin to understand the differing perspectives of other stakeholders, so you can work effectively right from the start of your engagement.

Fieldwork placement involves different specific requirements for each profession; for example, differing hours, definition of roles, delineation of suitable facilities, and guidelines for adequate supervision. There are also varying relational models between the professions and the universities. For example, placement may be undertaken during a qualifying degree, or during a graduate (post-professional) period. Further examples of relational models include universities that make direct payments to facilities for fieldwork placement as opposed to models involving no direct payment.

Despite these differences, each health and human services profession has key stakeholders in common, including the profession, the university, the government, the individual professional and you, the student. The need to balance the needs and expectations of stakeholders is constant, as well as imperative for the effective delivery of fieldwork placement.

The following is a broad-brush view from the perspective of each of the key stakeholders. Not all the issues will be discussed, and the level of detail is not exhaustive. The purpose of the discussion below is not to provide an in-depth synopsis of the discourse surrounding fieldwork education, but to shed light on the day-to-day dynamics of fieldwork placement.

The profession

A **profession** is the collective organisation of each specific work role undertaken by individual members of the health and human services workforce. *Professional associations* are the peak bodies representing the collective of the individual members of each profession.

Examples include Occupational Therapy Australia and AASW (Australian Association of Social Workers). In the context of this chapter, the core business of the profession is to define and assure standards of practice (including qualifying education) in the interests of the community, while concurrently advancing the standing of the profession within the community in the interests of the members of the profession. To that end, professional associations develop Codes of Ethics which serve as guides for individual practitioners in their day-to-day practice (Australian Association of Occupational Therapists 2001; Australian Association of Social Workers 2010).

The profession wants well-educated health and human services professionals. The profession needs to set standards for entry into the profession as well as standards for qualifying education. For example, in Australia the occupational therapy profession has minimum competency standards for new graduates that expand on seven major functional components for practice (Occupational Therapy Australia 2010). Each profession will also have a belief about the minimum number of fieldwork placement hours required to qualify.

The profession is an influential key stakeholder in fieldwork education. Nevertheless, it is not the core business of the profession to provide fieldwork education.

The university

A *university* is an institution that delivers higher education and advanced specialist knowledge through the integration of teaching, research and practice in the health and human services. In the context of this chapter, the core business of the university is to provide courses leading to suitably qualified members of the health and human services workforce.

The university is an influential key stakeholder in fieldwork placement. Nevertheless, it is not the core business of the university to provide fieldwork placement.

The government

The **government**, whether federal or state, is the organisation that provides funding sources for higher education as well as large areas of the Australian community's health and human services. In the context of this chapter, the core business of the government is to provide support for the needs, objectives and vision of the whole Australian community, both now and into the future.

The government wants people to work in the health and human services. The volume and complexity of that work is dramatically increasing and, now and into the future, workforce shortages are serious. Both federal and state governments are aware that this issue is critical. They are dedicating considerable resources to addressing the problems of getting the work done in the health and human services, including the development and securing of an adequate health and human services workforce.

Standards of services remain important to the government, but are not directly and solely linked to the standards set down by the professions. In 2008 the Council of Australian Governments (COAG) decided to establish and expand national registration for health practitioners as a means to assure standards (Australian Health Practitioner Regulation Agency 2012).

The government is an influential key stakeholder in fieldwork placement. Nevertheless, it is not the core business of the government to provide fieldwork placement.

The individual professional

The **individual professional** is the individual person doing specialist work within health and human services. Examples include occupational therapists, social workers, nurses, speech pathologists and physiotherapists.

In the context of this chapter, the core business of the individual professional is to provide the knowledge, skills and expertise required to deliver services that optimise outcomes in the interests of clients in health and human services.

Individual professionals want to meet the needs of clients through working in the health and human services. They also want to advance the visibility and influence of their profession. Individual professionals want to see an expanding workforce of well-educated and articulate colleagues in the field, primarily to meet the needs of a growing client base. At the same time, they take on a very demanding role, and the available resources are stretched. Their attention and energy must be devoted to giving the best services to their clients.

Individual professionals are influential key stakeholders in fieldwork education. Nevertheless, it is not the core business of the individual professional to provide fieldwork education.

The student

The final key stakeholder for discussion in this chapter is you! The *student* is the person who is the consumer of higher education, including fieldwork placement. You may be consuming fieldwork placement during your qualifying studies, after you have completed your coursework or as paid employment during your early working life. In the context of this chapter, your core business is to undertake fieldwork placement to fulfil the requirements for entry into the profession and therefore eligibility to join the health and human services workforce.

Students are keen to earn eligibility into the health and human services profession while balancing this aim with other life demands. As a consumer of higher education, the student is demanding more flexibility in the delivery of coursework, including using online and other digital technologies. Comparatively, there remains limited flexibility in fieldwork placement. Students understand that the relationship with the individual professional (fieldwork educator) is paramount. At the same time, students can be in the position of creating additional work as well as placing stress on other resources (such as computer access and desk space). Importantly, you, the student, are at the point of convergence between all the other key stakeholders. *You* are linked to and influenced by all the other key stakeholders in fieldwork placement. Your competency in professional behaviour, communication and ethical behaviour will be vital for effectively fostering partnerships with action during your fieldwork placements.

Students are influential key stakeholders in fieldwork education. Nevertheless, it is not the core business of students to provide fieldwork placement.

THINK AND LINK

Your growing competency in professional behaviour, communication and ethical behaviour is important. Chapter 10 outlines the different online technologies you could utilise. Chapter 3 will assist your ability to reflect on professional behaviour, and Chapter 12 provides a discussion on ethical practice with vulnerable clients.

IMPORTANCE OF FIELDWORK PARTNERSHIPS

The landscape for field education both internationally and in Australia is subject to constant flux, where rapidly changing economic and political imperatives have a constant impact upon workforce demand, employment opportunities, and health educational priorities and policies. In order to respond quickly to change and promote sustainability within health service delivery, the government, tertiary and industry sectors must now operate interdependently.

The last two decades in higher education have been characterised by increasing emphasis on partnering between education providers, industry and government. The potential gains for each of these stakeholders in finding common synergies have been widely documented (Etzkowitz 2008; Patrick et al. 2008; Orell 2011), with a growing realisation that more can be achieved for all parties through cross-sector collaboration than by operating separately. As such, there has been increasing recognition of the mutual benefits associated with cross-sector partnering in education and research. Specific drivers for partnering include: pooling resources and expertise; addressing identified areas of skills shortage; promoting professional development opportunities for industry staff through engagement with learning and research opportunities; improving retention among staff and student groups; fostering research and development opportunities between industry and higher education to address identified concerns; making indirect cost savings; information sharing; accessing different types of knowledge and skill; and drawing upon alliance networks and expertise to respond quickly to competitive pressures and funding opportunities.

While there are significant economic, commercial and pedagogical drivers for partnering, there are also qualitative advantages derived from collaboration between the government, industry and higher education sectors. These factors include the generation of goodwill and credibility in the community; using coalitions to promote diverse participation towards social justice objectives; and the demonstration of relevance and responsiveness to identified need, while fostering a creative milieu for the hatching of new ideas, development and research. These factors provide potent individual and organisational intrinsic motivation for initiating, supporting and maintaining cross-sector alliances.

REFLECTION

UNDERSTANDING STAKEHOLDER IMPERATIVES

This Reflection should be undertaken in pairs.

As discussed earlier in this chapter, there is a range of different stakeholders in fieldwork, including the professional associations, learning institutions, government and service delivery organisations.

- *Step 1*: Think about each of the different government, industry and professional stakeholder interests in fieldwork education, and identify which factors might be considered 'not negotiable' for these parties in negotiating educational fieldwork. Make a list of these. (Consider legislation, values and ethics, accountability, management principles such as communication and minimisation of risk, and organisational requirements.)

- *Step 2*: Ask yourself: what sorts of information and processes can I identify that might have been used in negotiating the terms of my discipline's fieldwork arrangements?
- *Step 3*: Ask yourself: what factors within the economic and political context do I think might have influenced the terms of my fieldwork placement arrangements?

THINK AND LINK

The Reflection also alludes to your role, rights and responsibilities. Chapter 2 discusses in depth the three Rs. This chapter may add thoughts to your reflections.

Partnering models

Partnering models have commonly been classified as either vertical or horizontal (van Ginkel 1999). **Vertical partnerships** are partnerships between organisations where one partner or group of partners acts as consultants (commissioned experts) to others wishing to make changes in their structure, functioning or methods of service delivery. **Horizontal partnerships** occur within a flat structure of governance, with expertise being shared between the partners, and the relationship is acknowledged as symbiotic. In these types of arrangements it is not uncommon for relational interactions between stakeholders to occur at strategic executive, operational and technical levels of the partnering organisations.

Most recently, the complex interchange of collaboration and innovation derived from industry, government and higher education cross-sector partnerships has been conceptualised as a **triple helix** (Etzkowitz 2008): the interconnected spiral relationship between these three stakeholders, where spirals are rarely equal, with one party acting as the core around which the others rotate. The institution that acts as the core spiral changes over time, depending upon the changing lifecycle, drivers and motivations of stakeholder interests in the collaboration. The helix formation manages to capture the more complex contemporary nature of relationships inherent in bringing together trilateral interactions between the three sectors, whereas traditional partnership arrangements were more likely to include only two sectors, such as university–industry or government–university.

Professional fieldwork in higher education is one significant area where the interests of each of these stakeholders intersect, creating a milieu for significant innovation, collaboration and potential conflict. We now turn our attention to the way fieldwork placements act as a microcosm for reflecting the broader debates in government education and employment policy, higher education pedagogical and marketing concerns, and industry capacity building.

Why do fieldwork partnerships matter?

The *Work Integrated Learning (WIL) Report* (Patrick et al. 2008) documents a scoping investigation into work-integrated learning in Australia. While the authors of this report were careful to note that fieldwork placements were just one type of work-integrated learning activity, they did highlight the centrality of cross-sector partnerships between university, government and industry providers to create relevant learning opportunities for students in the real world.

Stakeholders, especially students, stand to gain a great deal when symbiotic industry partnerships in fieldwork can be forged, and the WIL report cites these benefits throughout (Patrick et al. 2008). Hence, you have the opportunity to enhance your knowledge and skills in the authentic workplace; engage in activities that build strong curriculum vitae; develop professional networks for future employment; experience genuine practice opportunities in a supervised and 'controlled' environment; and test whether your chosen profession is really your occupation of choice.

Meanwhile, industry uses fieldwork partnerships as a means for strategic recruitment, gaining access to observe first-hand the work of potential future recruits during the practicum. Workforce recruitment is an expensive exercise, with the advertising and appointment process of base grade health professionals costing in the region of thousands of dollars. Your fieldwork placement provides employers with the opportunity to observe the work of potential employees (you) over a lengthy period of time without commitment to hiring, thus providing both you and the employer time to assess each other's strengths and weaknesses. A good number of final year health students gain their first graduate positions in agencies where they have been on placement.

THINK AND LINK

Chapter 26 discusses workforce recruitment, and how recruitment can relate to fieldwork placements. Fieldwork placement provides opportunities for you to consider where you would like to work, and for agencies to observe your performance as a potential employee.

Engaging students on placement also provides the means to promote professional development opportunities for agency staff through conducting student supervision and gaining access to university resources, such as the library and supervision training workshops. For these relationships to work, there needs to be a foundation of shared understanding about the purposes and expectations of each of the stakeholders. The importance of effective channels of communication between the parties cannot be underestimated. The coordination role of fieldwork arrangements should be acknowledged by all stakeholders as central to the success of the placement (Patrick et al. 2008). The legal and ethical responsibilities for fieldwork are generally acknowledged through formal contractual agreements between the health and human service industry sector and the tertiary education providers, with each discipline needing to adhere to the standards set down by its professional association for educating future professionals. Informally, the quality of the day-to-day communications between each of these parties greatly influences the degree to which reciprocity, respect and shared purpose for fieldwork placement can be developed. For these reasons student and stakeholder competency in demonstrating professional behaviour, sound communication skills and upholding ethical standards are vital during fieldwork placements. Not surprisingly, the informal networking and relationships between workers in organisations are frequently more powerful than the formally designated lines of accountability and control (Meads et al. 2008).

International fieldwork

Increasingly, Australian higher education institutions are partnering with industry and universities internationally to enable students to complete fieldwork placement abroad, while also hosting growing numbers of overseas students undertaking fieldwork in Australia. This developing trend is designed to keep pace with global changes in education and practice, to prepare graduates for working in the international context. While there is still debate about the pedagogical merits of international student placements at professional entry level, it is happening because of student demand.

Meanwhile, legislation developed out of concern for safeguarding the rights of international students visiting Australia (*Educational Services for Overseas Students Act* 2007) imposes severe restrictions on student visas, especially in regard to undertaking 'workplace training'. Also, employers have demonstrated reluctance to have international students on placement because of the limited potential for future recruitment and students' variable English skills and limited understanding of the Australian workplace culture (Patrick et al. 2008). Clearly more work is needed to develop mutually beneficial procedures and protocols between stakeholders to support this growing trend in undertaking international fieldwork. Partnerships are likely to include different stakeholders from those traditionally engaged, such as the Department of Immigration and Citizenship.

YOUR ROLE IN FIELDWORK PARTNERSHIPS

As mentioned above, it is not uncommon for you to gain access to your first graduate employment through a fieldwork placement. Being out in the field is your time to make a good impression, develop your professional networks and enhance the partnership arrangement for future cohorts of students. One of the significant findings from the recent WIL report was that an organisation's willingness to have students on placement was profoundly influenced by their experiences with earlier students (Patrick et al. 2008).

In your student role, you are clearly undertaking fieldwork to meet the requirements for your degree, but at the same time you are tacitly representing your discipline program and university. As such, you are central to building sustainable relationships between the industry and the learning institutions. Not all industry–university partnerships are robust; many can be tenuous, and experiences with students can either pave the way for future development between the parties, or result in ties between stakeholders being severed. Therefore, you have a powerful role to play as a conduit between the university and workplace learning environment, with the potential to add great value to the ongoing education of your peers. In this regard, your demonstration of professional teamwork skills, strategic networking and sound professional literacy are competencies that will serve to consolidate your future career, as well as the existing partnership between the university and agency.

After graduating, you have the opportunity to develop your management skills and career prospects by supervising student fieldwork yourself. Most institutions offer training opportunities to graduates interested in taking on this role. In so doing, you will be contributing to both the ongoing growth and development of your chosen profession, while strengthening the partnership between your employing agency and educational institution.

Students like to be supervised by alumni from their own degree program who are familiar with the curriculum and theory, fieldwork requirements and assignment expectations. Contributing to continuing education in this way will enable you to access ongoing learning opportunities from the education provider, while at the same time broadening your skills portfolio in the workplace. These proactive initiatives are in keeping with the competency of lifelong learning and will demonstrate your willingness to accept professional responsibility.

THINK AND LINK

Promoting professional development of yourself as a new fieldwork educator is discussed in Chapters 24 and 25. You may not have thought this far yet, but as a graduated health professional there is opportunity for you to engage students on placement as their fieldwork educator.

CASE STUDY

Forcefield analysis of the fieldwork enterprise

You are the director of an NGO (non-government organisation) with a staff of 25. The main focus of the work is in the area of aged care and disability. Your organisation has a small base in a regional town with several rural satellite offices. It has been hard to recruit qualified staff, and currently the budget is such that employees are overworked and stressed. The local university contacted you with a request to have two students on placement for a length of 70 days. The state government is offering a small funding incentive to rural agencies to support work-integrated learning for allied health students. Using **forcefield analysis**, consider if it is in the agency's interests to take on the students.

Forcefield analysis is a useful tool for weighing up pros and cons in decision-making. In conducting such an analysis, list all of the components integral to an issue and give each a weighting in terms of its impact on potential outcomes. Listed below are the factors that employers think about when considering having students on placement:

- funding arrangements for fieldwork
- risk management
- assessment of student performance
- insurance coverage
- workforce planning and policy
- staff development
- recruitment
- implications for service delivery
- agency capacity to support and oversee day-to-day student activity
- costs to the agency
- health and safety
- special requirements to meet students' personal circumstances (such as care of ageing parents or a disability)

- compatibility with organisation mission and other workers
- workload implications
- agency employment requirements (such as police checks or possession of a driver's licence).

QUESTION
Identify the likely positive and negative factors associated with each of the above items that need to be taken into account before making your decision on whether or not to have students on placement.

SUMMARY

The aim of this chapter was to provide a practical introduction to the day-to-day dynamics of fieldwork education in the health and human services. In addition, we have encouraged you to think critically about partnerships in fieldwork placement. The perspectives of key stakeholders were introduced as a platform for discussing your role in fieldwork partnerships. You, the student, are a key contributor to (not just consumer of) fieldwork placement in health and human services. Issues of governance and sustainability are examined in relation to the delivery of fieldwork and the student role.

Discussion questions

1 What do you think some of the legal, political and economic tensions might be for government departments, professional associations and industry partners in developing long-term, sustainable fieldwork models for educating future practitioners?

2 Where does the power rest in negotiating fieldwork with students, the university, industry or government departments?

3 What are the synergies between your personal values and those of the stakeholders involved in your fieldwork education? Give an example of a contribution you're prepared to make that results in mutual benefit for yourself and another stakeholder.

Portfolio development exercise: A critical appraisal

Using the factors listed in the forcefield analysis exercise (see the case study above), and the principles outlined in your professional Code of Ethics, write a critical appraisal of the organisational and ethical dimensions presented in the case below. Discuss in particular how the various stakeholders in the scenario have a range of interests and how they are affected in diverse ways. This exercise aims to consolidate your competencies in professional literacy and ethical behaviour.

Case: An influx of migrant and refugee families have been settled in a particular rural town to address labour shortages in farming, fruit picking and the local abattoir. This arrangement has been in keeping with federal government policy to encourage workers with migrant

and refugee backgrounds to repopulate and provide labour in rural regions. The nearest university (60 kilometres away in the city) is looking for rural student placement opportunities in the health sector to boost the number and range of placement sites. Meanwhile, the rural community health centre in the small town is keen to have allied health students to help address the exponential increase in workload since the arrival in the area of over 30 families during the last eighteen months. The families are predominately from war-torn nations, have had traumatic times in camps before migrating, experience seriously compromised health and have few English language skills.

As a student, you have been placed at the health centre and asked to assist with setting up a number of community initiatives to help the refugee and migrant families, including a mothers' and children's playgroup. You are struggling to cope with the enormity of the needs presented by the client group (including the women's and children's responses to torture and trauma, severe poverty and mental health issues). It is difficult to communicate with family members if the one official interpreter (paid for by the Hospital Board) is not present. You seek advice and support from your supervisor from the centre, although you notice she is not particularly familiar with the cultural imperatives of working with these newly settled families. Supervision sessions are meant to be regular, but rarely occur. When you do have supervision, you find your supervisor is herself overwhelmed by the workload and the complexity of the changed social dynamics in the town. She appears burnt-out and unable to help you.

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CHAPTER 12

Supporting People's Decision-making

Geneviève Pépin, Joanne Watson, Nick Hagiliassis and Helen Larkin

LEARNING OUTCOMES

After reading this chapter you should be able to:

- describe the interrelationship between duty of care, risk and decision-making capacity
- describe and apply suggested tools to different contexts of decision-making
- explain the risks and factors influencing decision-making processes
- identify strategies to facilitate decision-making for vulnerable decision-makers.

KEY TERMS

Capacity
Doughnut principle
Duty of care
Person-centred risk assessment
Risk assessment
Supported decision-making
Vulnerable decision-makers

INTRODUCTION

Health professionals and other service providers have a legal and ethical responsibility 'to carry out their duties with sufficient care so that the service user does not suffer injury or loss as a consequence' (Baxter & Carr 2007: 7). This duty of care is informed through: professional codes of conduct; organisational policy and processes; state and federal statutes and standards; legal precedent; and national and international health and human rights charters. Much of the available literature (Villamanta Legal Service 1996; Ellis & Trede 2008) explores the interpretation of duty of care in everyday practice, and the need for health professionals to ensure that service users have the opportunity to make as autonomous decisions as possible.

Implicit in the exercise of duty of care is that people understand the information and choices being presented, and the consequences that may arise from a particular intervention or approach. However, the obligation to exercise duty of care is further complicated when a person's competence is called into question, or when health professionals are unsure as to the person's capacity to understand all of the issues and the potential consequences of either action or inaction.

This chapter addresses a number of practice issues in the application of duty of care for people who are considered to be **vulnerable decision-makers**. By 'vulnerable decision-makers', we are referring to adults with disabilities, such as developmental disabilities, psychiatric disorders and neurological deficits, for whom the characteristics associated with their condition can affect decision-making. These characteristics may include:

- difficulties understanding and communicating the available options and their advantages and disadvantages
- difficulties demonstrating judgment, reasoning and insight about certain choices
- presence of an interfering pathological perception, such as a delusional system, or interfering emotional state, such as severe depression or euphoria (adapted from Stebnicki 1997).

It is important to bear in mind that just because someone has a disability, it does not mean they have impaired decision-making competence. As a starting point, health professionals should assume competence when working with someone with a disability. However, for some, particularly those with more severe or enduring disabilities, difficulties in making decisions independently will be present.

In such circumstances, health professionals can face dilemmas and uncertainty in relation to a person's health and wellbeing when attempting to reach agreement about his or her competence to make choices those health professionals may consider unwise or potentially dangerous. This uncertainty can result in negative and paternalistic practice 'in which assumptions are made by professionals about what is best for the service users in their care' (Baxter & Carr 2007: 7). This is often based on a fear of causing injury or other adverse event and the risk of consequent prosecution.

Therefore, it is crucial to acknowledge the complexity of supporting the decision-making of persons who are vulnerable. This chapter will provide guidelines and tools to ensure that you, as a healthcare professional, are better equipped to understand this complexity, and support the decision-making process of vulnerable persons so that the duty of care to protect the human rights and dignity of this group is not neglected.

ENHANCING COMPETENCE

Capacity and decision-making among certain vulnerable groups has seen much evolution. Historically, the approach adopted in this area has been paternalistic; that is, one in which decisions were made on behalf of people identified as vulnerable, underpinned by the attitude that people with disabilities do not possess the intellectual or personal capacity to contribute to decisions about their lives. This resulted in numerous injustices for people with disabilities, such as medical treatment and hospitalisation without consent, loss of control of finances and mass institutionalisation (Fennell 1996).

Over recent decades, there has been an emphasis on the rights of people with disabilities to make, or at least participate in, decisions that reflect their preferences, including those with severe and enduring disabilities. The right to self-determination through decision-making is enshrined in numerous pieces of legislation around the world (Scottish Parliament 2000; Victorian Government 2006; Department of Health 2007). The United Nations Convention on the Rights of Persons with Disabilities (United Nations 2006) stipulates that all persons with a disability have legal decision-making capacity and must be supported to the greatest extent possible to exercise that capacity. Signatory nations to this convention, Australia being one of them, have an unambiguous obligation to ensure that these principles are upheld for all citizens. The principle is increasingly evident in legislation in a range of jurisdictions. For example, in Victoria, Australia proposed new guardianship legislation recommended by the Victorian Law Reform Commission acknowledges that a person's decision-making competence should not be defined purely by their level of individual cognitive capacity, but by the degree of support available to help them make decisions (Victorian Law Reform Commission 2012).

Around the world, there are various practice approaches in use. These fall on a continuum, from supported decision-making (the focus of this chapter) to substitute decision-making. The particular supported decision-making model presented in this chapter includes a focus on the types of supports a person needs in order to be maximally involved in decisions that affect their lives. This differs in orientation to substitute decision-making approaches, where the decision-making power rests with a guardian, administrator or some other 'responsible person'. A supported decision-making approach differs from a substitute decision-making approach in many other ways, but a discussion of these differences extends beyond the scope of this chapter. One key difference is that a supported decision-making approach does not rely on the need to establish a person's capacity, such as through 'capacity testing'. As Beamer and Brookes (2001: 4) state,

> the starting point is not a test of capacity, but the presumption that every human being is communicating all the time and that this communication will include preferences. Preferences can be built up into expressions of choice and these into formal decisions. From this perspective, where someone lands on a continuum of capacity is not half as important as the amount and type of support they get to build preferences into choices.

This legislative and practice shift is underpinned by principles of human rights and the right of self-determination of people with disabilities, recognising that a fulfilling life must include the right for people with disabilities to make choices and have control over their lives. There has been a concurrent shift in the way health professionals approach the issue of decision-making for people with disabilities. It is becoming increasingly recognised that duty of care includes the concepts of both minimising harm and facilitating individuals' rights and choices (O'Brien 1992, cited in McKenzie et al. 2001).

When reflecting on practice it is necessary for you to examine your attitudes. 'While the concept of duty of care exists for the protection of vulnerable clients it should not preclude risk-taking' (McKenzie et al. 2001: 30). It is important to promote choice and participation, but do this, where appropriate, in a context of risk minimisation and management and not necessarily risk avoidance. This is not always easy, as it requires a recognition and objective interpretation of the belief systems and premises that underpin practice, but it is a critical

element if one is to adopt a supported decision-making approach. This is why throughout this chapter you will be invited to think critically and use your judgment in developing your understanding of the underpinnings of decision-making, their interdependence and impacts on solving problems around supported decision-making.

EVALUATING CAPACITY

Another major shift has been in the health professional's role in tests of *capacity*. Traditionally and currently, healthcare professionals, particularly psychologists and psychiatrists, are involved in assessing an individual's capacity to make a specific decision. This approach is often criticised on the grounds that it implies an all-or-nothing judgment; that is, one in which capacity is either all present, or all absent (Stebnicki 1997). Furthermore, it generally does not discriminate between the types of decisions, or the context or environment in which the decision would be implemented. As for everyone, capacity can fluctuate depending on the specific decision at hand, the specific moment in time, and the environment and experiences of the individual who is making the decision. An all-or-nothing judgment does not capture these intricacies.

A finding of capacity is a legal decision made by the courts, or a legal mechanism of adult guardianship, as opposed to a more 'medical model oriented decision' made by a health professional. However, health professionals are at times requested to provide opinions and formulations to inform decisions of capacity. The measurement of capacity is fraught with difficulties. Iacono and Murray (2003: 45) state that 'there remains no clear indication of the threshold of performance needed to decide if a person demonstrates decisional capacity'. There is also not, nor should there be, a single evaluation instrument or set of instruments to determine a person's capacity for decision-making, or even agreement on what such an instrument should comprise conceptually. An integrated assessment approach is recommended, combining information from any formal assessments, with other relevant systemic, interpersonal and contextual information. Health professionals should always keep records of the approach/es taken to evaluate capacity. When in doubt, you should undertake further reading and seek advice. Professional opinions should always take into account the rights of the person with a disability, professional and ethical obligations, and any legal considerations.

The following are general considerations for health professionals forming opinions about a person's capacity. Importantly, consistent with the view presented by Beamer and Brookes (2001), the starting point is not a 'test' per se, but rather identifying the types of information and supports the person needs to make a decision as independently as possible. Generally, the conditions of adequate information, understanding, voluntariness and the presence of support need to be met. Listed under each of these categories are some questions for health professionals to think about (adapted from Iacono & Murray 2003):

- *Adequate information*: Is information being provided in an accurate, balanced and accessible way (e.g. using assistive communication strategies, having someone else assist in explaining things, giving the person time to process and weigh things up)?

- *Understanding*: Does the person understand, or at least have an appreciation of, important aspects relating to the decision (e.g. what the issue is, what the potential benefits and risks are, where to go for help or more information, any legal considerations)?
- *Voluntariness*: Are you confident that someone else's agenda is not driving the decision?
- *Presence of support*: Where necessary is support being provided by a group of people who know the person well and have their best interests at heart?

WHAT IS YOUR ROLE?

Duty of care

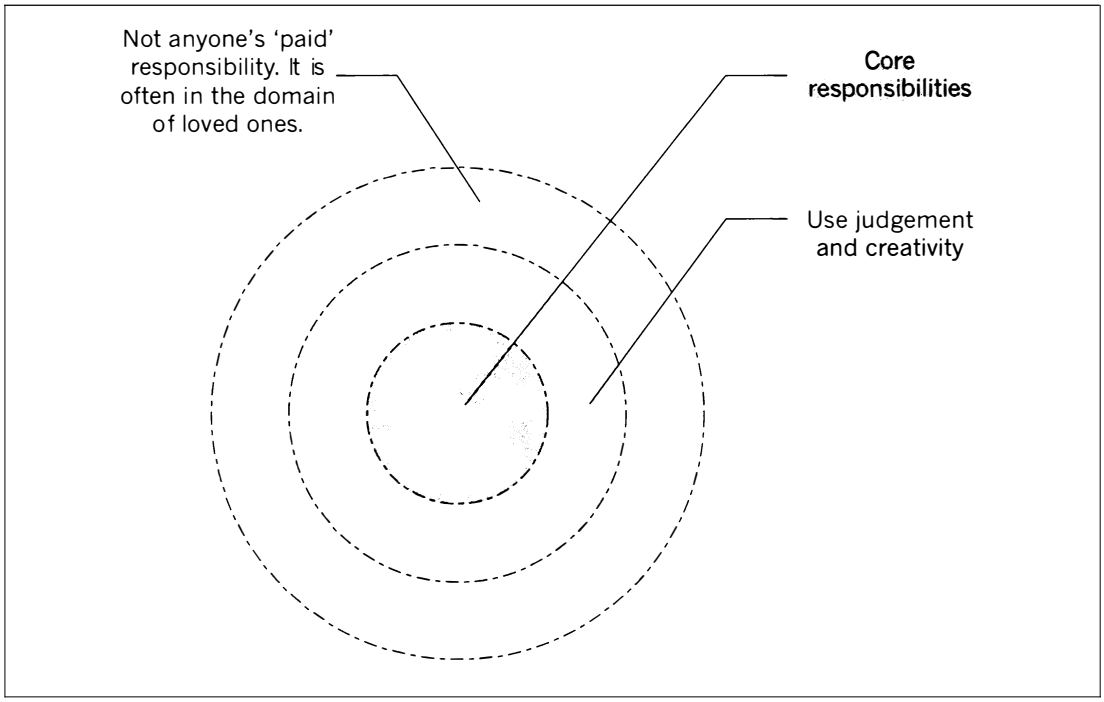
One of the most difficult but critical and underestimated skills for anyone working in health and human services is creating clarity around roles and responsibilities. Do you have a **duty of care**? In which context do you have a professional duty of care? To whom do you have a duty of care? What is clearly within this duty and what falls outside of these obligations and responsibility? These questions start the exploration of the link between duty of care, *decision-making capacity* and *risk* for those people who are considered to be vulnerable (McKenzie et al. 2001).

Charles Handy's **doughnut principle** (Handy 1994), although developed as a management tool, is also relevant for understanding the roles and responsibilities of those working in health and human services. Adapted by Michael Smull (1996) as a person-centred thinking tool, it can also be used by health professionals to determine their level of involvement when supporting someone with a disability through a decision-making process. The doughnut (Figure 12.1) has three concentric circles. The first, inner, circle is identified as core responsibilities. These are responsibilities that health professionals clearly have a duty of care to carry out, such as following applicable legislation, policies and procedures. The second, outer, circle refers to situations in which professionals may have an unclear duty of care. They may be required to use creativity and sound judgment yet should not force their views on the person. Finally, the outer ring contains those aspects of a service user's life that are not the responsibility of paid health professionals, such as making moral decisions. This area is usually the domain of the person him- or herself in collaboration with those who know and love that person, such as family and friends.

Smull (1996) explains that the boundary between 'core responsibilities' and 'judgment and creativity' is usually well defined. In contrast, the boundary between 'creativity and judgment' and 'not paid responsibility' is more likely to be blurred. For example, prescribing a piece of equipment such as a wheelchair, which fits the person's needs, environmental factors and personal circumstances, could clearly be the duty of care of a health professional. However, it may not fall within his or her duty of care to oversee mobility in other areas of the person's life, such as a choice of leisure activities or travel plans.

The doughnut principle provides a useful framework for health professionals who are deliberating on their level of involvement around a decision, and conceptualising the difference between activities across these three zones.

Figure 12.1: The doughnut principle



Source: Adapted from Handy 1994

REFLECTION

DUTY OF CARE

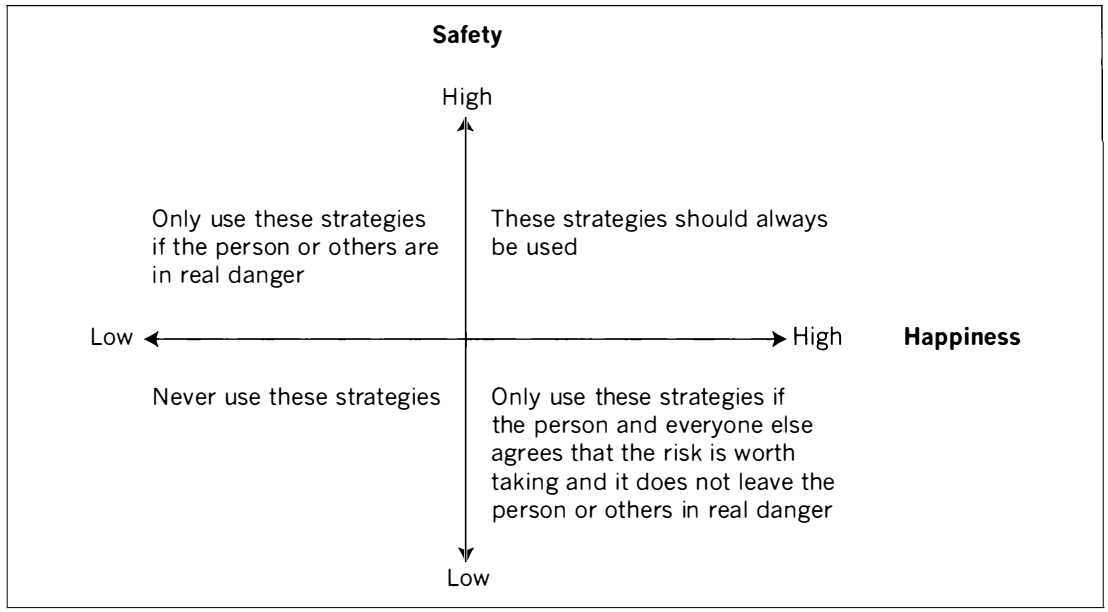
Reflecting on your fieldwork experiences, think about a person (or a client) for whom the question of duty of care applies.

- Do you think you, or others, had a duty of care?
- How was duty of care applied?
- Were any decisions made on the person's behalf?
- To what extent was consideration given to the person's preferences?

Risk or opportunity?

If through the doughnut principle you determine that you have some professional responsibility for the person in question, the next question to ask is: what is the level of risk involved? The **person-centred risk assessment** (Kinsella 2000), shown in Figure 12.2, identifies 'safety' and (the person's) 'happiness' as important factors to consider when weighing up risk. It has been developed to explore the relationship between risk and the importance of an

Figure 12.2: The person-centred risk assessment



Source: Adapted from Kinsella 2000: 3

issue to the person, and problem solve around this relationship and identify strategies that balance safety within the context of the person's happiness.

Implicit in this approach is a strong collaboration between the person and the people who care for him or her, knowing that person well and having his or her best interests at heart. Risk is multidimensional, and any risk assessment should reflect this. It is important to consider the consequences of the potential risk, not only on the person, but also on those supporting that person and on others within his or her community. In terms of the person taking the risk, it is important to consider the impact of the activity on the person's reputation and on how this person may be perceived. Just as important is consideration of whether there is any risk of lost opportunities for personal development if the person does not engage in the activity. Ask yourself if what you are assessing is a potential risk or a true opportunity.

As you move along the safety and happiness continuum of the person-centred risk assessment, you will be able to visualise and identify the impact of a specific scenario or example taken from your fieldwork experience. What level of safety is involved in this scenario? How does it translate on the happiness continuum? Do the risks outweigh the happiness, or to the contrary? Will the person's decision imply minimal risk and create a high level of happiness, or will it jeopardise his or her safety to the point of unacceptable risk to the person or others, where it 'may be necessary to intervene against the apparent wishes of clients in order to protect them from harm or unacceptable risk, particularly if their choice is not an informed one' (McKenzie et al. 2001: 29).

If you determine that you have a professional responsibility in relation to the person and there is an element of risk, the next question to ask is: is the person able to understand the consequences that may arise out of any action that he or she takes or is undertaken on his or

her behalf? In this situation, discussion and intervention generally focus on an assessment of the person's competence to make a choice and to understand the consequences of these choices. The next section explores the concept of competence as it applies to vulnerable decision-makers.

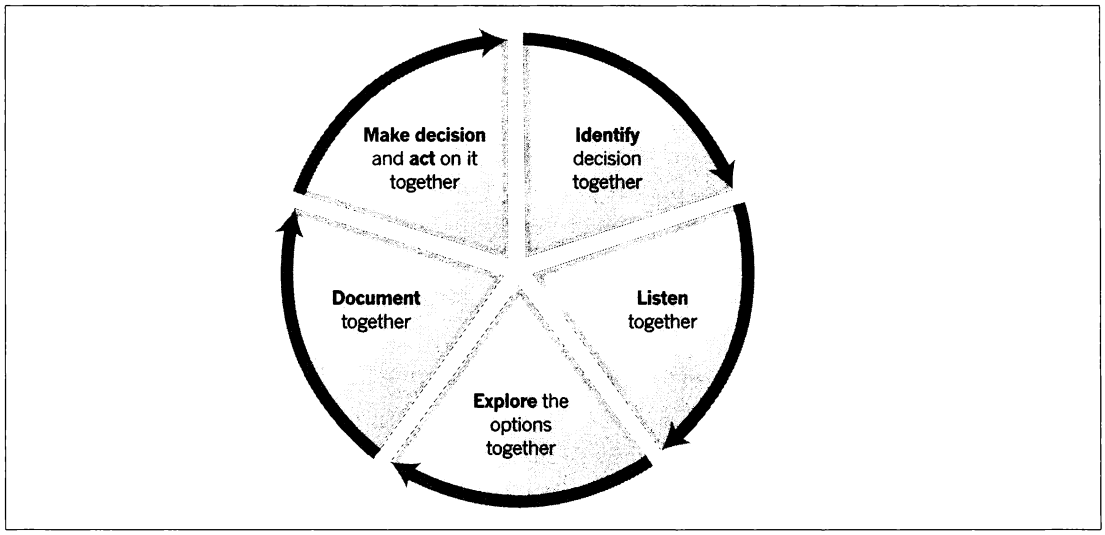
MODEL OF DECISION-MAKING SUPPORT

A **supported decision-making** approach has at its heart the principles that everyone is competent in participating in decisions, everyone communicates and we all seek support to make decisions from those we know and trust. The question that needs to be asked is what type and degree of support does the person need to build their preferences into decisions? Where there is uncertainty about a person's decision-making competence, our response must be based on the assumption that every human being is communicating, and that this communication will include the expression of preferences. With support, preferences can be built up into expressions of choice and from there into formal decisions.

This section presents a five-phase model developed by Joanne Watson to promote choices and to support decision-making for people who may be considered vulnerable decision-makers in some aspects of their daily life. Although this model has been developed with the specific needs of people with significant intellectual disabilities in mind, its principles are applicable to all decision-makers, regardless of their vulnerability. The model is embedded in a training package, which includes a training video that can be viewed at www.scopevic.org.au.

The training package is directed towards whole teams, bringing together a group of people who care for and about a particular person with a severe to profound intellectual disability (circle of support). Together this group are asked to engage in a process of supported/co-decision-making over a period of time (usually three to six months), specifically targeting the focus person and a decision they are faced with. The framework is comprised of five separate but interrelated phases. It is designed to gather a consensus view on what a person may be communicating and/or what is in their best interests and from there make a decision. The framework does not claim that supported/co-decision-making is a simple process, and recognises that the role of supporters is a highly responsible one, requiring an understanding of the person and their preferences, and a desire to respect the dignity of the represented person, who may be particularly vulnerable. Although the package has been designed around the needs of people with an intellectual disability, a supported/co-decision-making model is not a clientele specific tool but a framework for truly reaching the heart of people's desires, preferences and dreams regardless of the challenges they are facing. It recognises a person's capacity to make or participate in a decision in a given context by including and considering contextual factors. It can be used in supporting vulnerable decision-makers to make and participate in decisions regardless of their disability (see Figure 12.3).

Figure 12.3: The supported decision-making model



Source: Watson 2011: 7

CASE STUDY

Lillian's story

Lillian's story is an example of the application of the different tools presented previously in the chapter when considering and supporting a person, who can be considered as being vulnerable, in making decisions.

Lillian is 78 years old and lives on her own in a retirement complex, her husband having recently died. She manages most of her daily living tasks, although has some assistance from her local council with household tasks including weekly shopping. She uses a frame to assist with walking inside and is unable to walk long distances outside her home. Lillian has early signs of dementia, which has an impact on her short-term memory and motor planning, including when she gets out and about in the community.

Lillian wants to be able to go to the shop, post letters and meet her friends at the central facilities of the retirement complex. She has been referred to Jane, an occupational therapist from the local community health centre, to assess her suitability for a powered wheelchair.

In this situation, Jane has a clear duty of care to Lillian (using Figure 12.1) to ensure that she is safe if a mobility scooter is to be prescribed. As part of the mobility assessment, Jane needs to consider if Lillian's use of a powered wheelchair will involve potential risk to herself or to others. Jane undertakes a full assessment of Lillian's ability to safely mobilise from her home to the facilities complex. The potential risks identified by Jane are:

- there is no continuous accessible footpath between Lillian's home and the complex; therefore, Lillian will need to use a roadway for approximately 150 metres
- Lillian's motor planning and response times are slowed and she has difficulty managing the speed control on the scooter
- the roadway is a circular driveway with a hedge, so her visibility in the wheelchair to oncoming cars is restricted.

Using Kinsella's person-centred risk assessment (Figure 12.2), Jane balances Lillian's desire for independence with her need for safety. Jane determines that in this situation, Lillian's 'potential for happiness' is high but that there is some risk. However, it is Jane's opinion that the risk can be managed and minimised. Jane arranges with the wheelchair supplier for the joy stick controls to be dampened, thus slowing down the speed and reactivity and making it easier for Lillian to control the wheelchair. A visibility flag is also to be located on the back of the wheelchair. The driveway that Lillian will need to use is an internal roadway and is speed limited to 10 km/h and therefore the likelihood of an accident is considered minimal. In the meantime, Jane discusses the need for a footpath with management of the retirement complex.

Jane also arranges that Lillian will have a series of supervised practice sessions when her wheelchair is first supplied. Jane determines that there is no risk to others with Lillian's use of a wheelchair, that the risk to her is minimised, and that her need and desire to be independent overrides the minimal risk that remains.

Having discussed the issues with Lillian and her family, Jane is confident that Lillian: is safe using the wheelchair between her home and the facilities complex; understands the risks involved; has become familiar with the pathway between her home and the complex; and has committed to not using her wheelchair in unfamiliar circumstances. Jane has documented in Lillian's file each of the discussions and processes that have occurred. In this situation, there is no need to apply the supported decision-making model. In this example, Jane revised and critically analysed her knowledge, used her judgment to understand the context and adapted her knowledge to support Lillian's decision-making.

Six months later, Lillian has a major stroke. While undergoing rehabilitation, the allied health team suggest that she is unable to return home and needs to find a place in a residential care facility. While having experienced further cognitive decline as part of the stroke, Lillian clearly states that she wishes to return home. Using the Kinsella model to determine that there are serious risks associated with this, the team adopt a supported decision-making approach to ensure that Lillian's desires and preferences are fully accounted for.

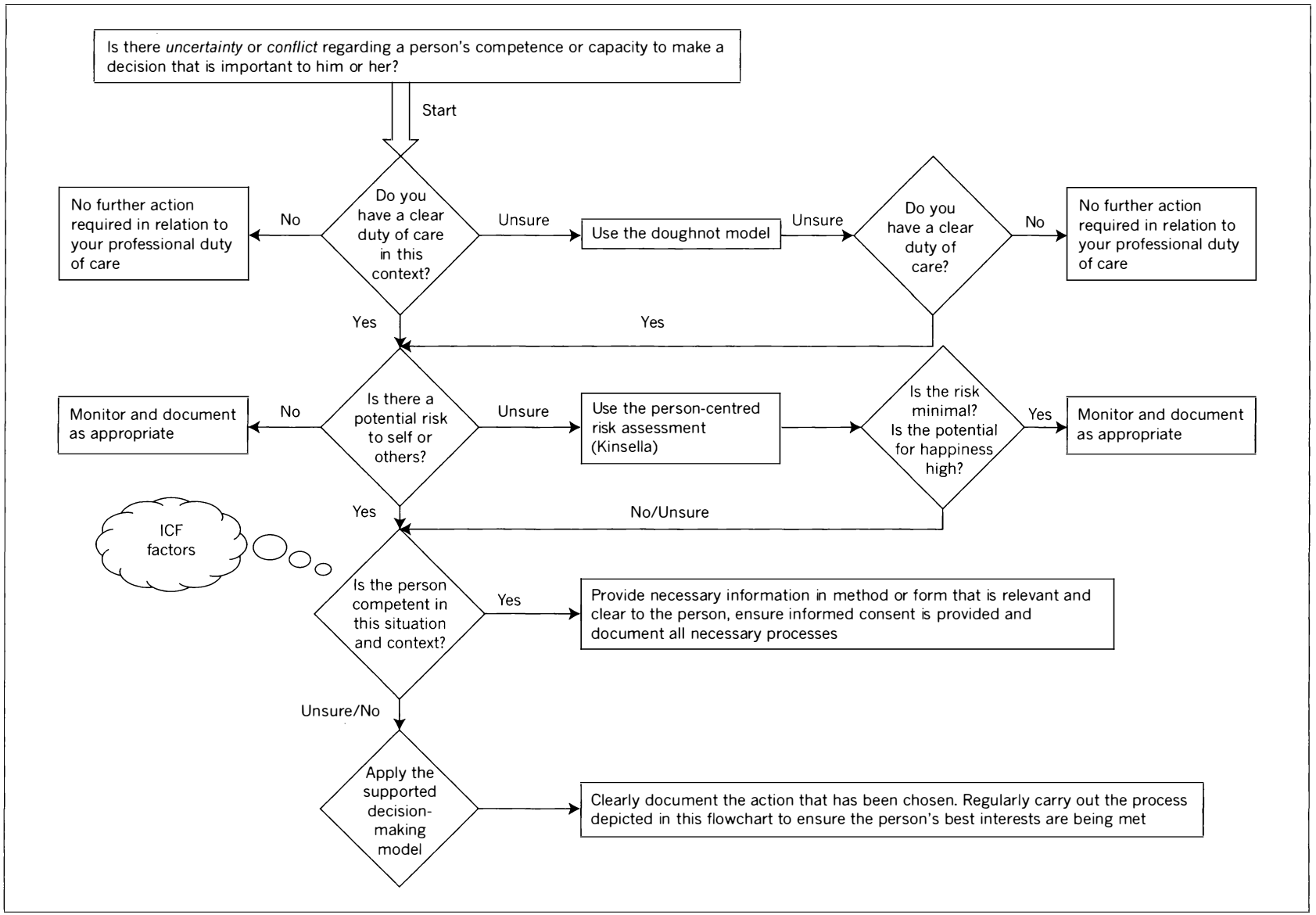
THINK AND LINK

Figures 12.1 to 12.4 are practical in their applications to patients and clients who you may meet in practice in a variety of contexts. Part 2 is about contexts of practice and these tools could be applied to some of the patients and clients who are the focus of these chapters.

A PATHWAY FOR GUIDING PRACTICE

This section presents a pathway that can be used to guide collaborative team thinking when there are questions around professional duty of care, risks and competence may have an impact on decisions to be made about, with or for a person (see Figure 12.4). This pathway summarises, in diagrammatic form, the information contained in the previous sections of

Figure 12.4: The decision-making pathway



this chapter, and is designed to help you navigate through the decision-making processes. It highlights important questions that should be asked along the way, and provides strategies for implementation.

SUMMARY

In the case of vulnerable decision-makers, your role is to share in the decision-making process with other people in the person's community of support, rather than to take on the role of substitute decision-maker. Such a community of support, composed of health professionals and others, collaboratively contributes opinions about enablers and barriers to a person's decision-making capacity and strategies for addressing these. Having a number of people involved offers a safeguard against any individual who might try to exert undue influence. The composition of a community of support should be led by the individual at the centre of the decision. This implies there will also be occasions when there is no role for a specific health professional, either because his or her expertise is not relevant in that case, or because the individual has made a decision to that effect. This does not prohibit this health professional from challenging the decision made by the community of support if he or she feels that the decision of the group is not in the person's best interest.

This chapter has outlined a process for you and others who support people who are considered to be vulnerable decision-makers or where questions arise in relation to a person's competence to make choices and decisions in everyday life. The tools described within this chapter are offered as one way forward by which healthcare professionals can bring together what may be differing professional and personal perspectives and life experiences to bring about solutions that are more rigorous, inclusive and respectful of every person's right to participate to their maximum potential in their chosen lifestyles and communities.

Discussion questions

1 Think about a time in your life where you felt you were taking a risk. How did you make your own decision? Who did you talk to? Who did you consult? What support did you get? What did you get out of this experience?

2 Reflect on your own attitude and belief system, and the impact these can have on the people to whom you provide service. Which attitudes and beliefs restrict the implementation of supported decision-making? Which attitudes and beliefs facilitate the implementation of supported decision-making?

3 Reflect on a past or current situation where you thought you had a duty of care. What are your thoughts on this situation now? What could or would you do differently?

Portfolio development exercise: Practising supported decision-making

This Portfolio Development Exercise has been developed to help you to apply your knowledge, demonstrate your understanding of the concepts discussed in this chapter, and provide evidence you have developed the competencies of this chapter, which are to:

- synthesise and consolidate your knowledge about complex decision-making
- exercise critical thinking and judgment in developing new understanding of supported decision-making processes
- adapt your knowledge and skills to diverse contexts of decision-making
- demonstrate theoretical knowledge and reflect critically on theory and professional practice.

Case studies

This section presents the stories of three people. When you read Doug's, Sarah's and Sam's stories, keep in mind the information, strategies and tools presented earlier in this chapter. For each scenario:

- ask yourself if you have a professional duty of care in the context described
- reflect on the notion of risk potentially involved in the different scenarios
- consider the contextual factors for each person, and how they can enable or be a barrier to facilitating individual's rights and choices
- identify strategies to limit or eliminate the barriers.

These broad questions will prepare you to analyse each story from a supported decision-making perspective. A worksheet has been developed especially to help you apply the different concepts related to supported decision-making to Doug's, Sarah's and Sam's stories.

Case study: Doug

Doug is a 28-year-old man who acquired a head injury at 21 years of age. He uses speech to communicate, but sometimes this is difficult for others to understand, so he augments this using a text-to-speech electronic communication aid. His cognitive abilities have not been formally assessed, but it is estimated he has a mild learning disability. He is also observed to have limited literacy skills. At times he is impulsive in his actions, while he has been observed to be emotionally labile and easily agitated. He lives in supported accommodation. Through an informal arrangement, support staff assist him with most financial affairs, but he also has independent access to his money.

Recently, support staff have become concerned about frequent withdrawals from his bank account. When asked, he openly explained that he was using this money for gambling purposes, and that this was an activity that he enjoyed. He became agitated when it was suggested he should cease spending his money in this way. Further, he revealed that he was accessing these funds through ATM withdrawals at his local gaming venue, but was asking other patrons to perform these transactions on his behalf. Staff are concerned that his understanding of money is limited, and that he does not understand the financial implications of his actions. They are also concerned that, through having others withdraw money on his behalf, he may be placing himself in an unacceptably vulnerable position.

Case study: Sarah

Sarah is 19 years old. She was diagnosed with anorexia nervosa when she was 16. Since then, she has been in and out of hospital several times. Sarah has said repeatedly that she does not have a problem, but while she was under age, her parents managed to get her to see different specialists. Sarah's parents are still very concerned about her health and wellbeing but now that she is an adult they feel there is little they can do but hope that she will realise she needs help. Recently, Sarah was hospitalised after fainting while waiting for the bus. At the hospital, Sarah was rapidly diagnosed with severe anorexia nervosa, and was transferred to the eating disorders unit in the psychiatric ward. Sarah refuses any type of intervention and wants to leave the hospital. The multidisciplinary team wants to start legal proceedings to demonstrate that she cannot make informed decisions about her medical treatment, and needs to stay in the hospital, even if it means staying as an involuntary patient. Sarah has decided to discharge herself despite her condition.

Case study: Sam

Sam is a 64-year-old man with cerebral palsy. He has a severe intellectual disability and difficulties eating and drinking. Some of the people who know and love him, including his sister Beth, have indicated that one of Sam's greatest pleasures in life is drinking cool, fizzy lemonade. When the lemonade enters Sam's mouth he hums loudly, and rapidly moves his tongue in and out of his mouth. He also giggles when small quantities of lemonade are placed on his tongue. Although Sam receives most of his nutrition via a gastrostomy tube, Beth offers him a drink of lemonade each morning. Beth is a registered nurse with many years of experience in geriatrics, and she has also been appointed as Sam's legal guardian. The speech pathologist supporting Sam believes that thin fluids are dangerous as his swallowing difficulties are such that the fluid is highly likely to be aspirated into his lungs. Sam is currently living with Beth, and receives personal support and therapy services from a local disability agency. Sam is often hospitalised as a result of pneumonia, which is believed to be caused by the aspiration of food and drink. After these hospitalisations he usually receives services from district nursing for several weeks.

Exercise

Apply the decision-making pathway (Figure 12.4) to each case study. Complete one of these worksheets for each case study.

1 For each case study, write briefly the issues contained in the case study where you think there is uncertainty or conflict about the person's decision-making capacity.

   a Case Study Doug

   b Case Study Sarah

   c Case Study Sam

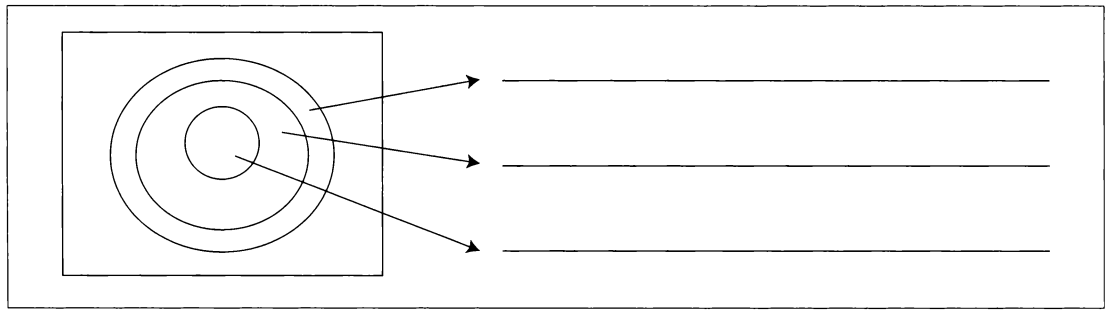
2 How many issues were you able to describe?

   a Case Study Doug

   b Case Study Sarah

   c Case Study Sam

3 Using the **doughnut model**, locate each of the issues on the chart below for each case study.



Do you have a clear duty of care in the context described in any of the issues listed above? Yes/No

4 If you answered Yes, locate these issue(s) on the person-centred risk assessment (reference) grid (see Figure 12.2).

5 Using the supported decision-making model (see Figure 12.3), describe the actions that you or the team could take to ensure that the person's best interests are being met.

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CHAPTER 13

Working in Palliative Care

Lorna Rosenwax and Sharon Keesing

LEARNING OUTCOMES

After reading this chapter you should be able to:

- describe palliative care and its use by allied health professionals
- appreciate the range of communication strategies required in the delivery of a palliative approach to people who are dying and their carers/families
- understand the range of environments in which the palliative approach is delivered
- reflect on the challenges and opportunities of working in this context
- apply this knowledge to examples and case studies.

KEY TERMS

Good death
Good enough death
Family-centred care
Illness trajectory
Palliative approach
Palliative care
Terminal phase

INTRODUCTION

As a student health professional, there is every chance you will come in contact with someone who is dying. It may be in a hospital setting, a residential aged care facility or a community setting. It may be in the metropolitan area or a rural town. It may be someone who is elderly, a young mother or even a child. The death of a close friend or relative may have already occurred in your private life. Many people believe you have to be a special person to work with people who are dying and their families. Others believe it is a privilege. What may surprise you is that, as a student health professional, you probably already have

many of the competencies and knowledge to work in a palliative care setting. With the right attitude, an understanding that working in **palliative care** requires cultural competency and a high level of communication skills, and some generic professional skills, you should find this fieldwork placement challenging but successful.

PALLIATIVE CARE

Palliative care is generally delivered to people who have a disease or clinical condition that is progressive (it is getting worse) and there is little or no prospect of cure. Palliative care has traditionally been provided to people dying of cancer, but is now also provided to people where death is clinically expected such as people with chronic renal, heart, obstructive pulmonary or liver failure; people with Parkinson's disease, Alzheimer's disease, motor neurone disease or Huntington's disease; or people with HIV/AIDS (McNamara et al. 2006). It is *not* the aim of palliative care to cure disease or to continue invasive treatments. The aim in a **palliative approach** is to achieve the best quality of life for the dying person and the person's family before a dignified, peaceful and timely death. The Department of Health and Ageing (Australian Government 2010) provides an explanation of palliative care which assists with understanding the philosophy of palliative care:

- affirms life and treats dying as a normal process
- neither hastens nor postpones death
- provides relief from pain and other distressing symptoms such as shortness of breath, fatigue, anxiety, depression, vomiting, constipation, confusion, anger, fear, social concerns and spiritual concerns
- integrates the physical, psychological, social, emotional and spiritual aspects of care, with coordinated assessment and management of each person's needs
- offers a support system to assist people to participate within their limitations in activities, such as social encounters, daily routines, managing personal business and recreational pursuits, as actively as possible until death
- offers a support system to help the family cope during the person's illness and during bereavement.

REFLECTION

Reflect on the previous paragraphs and consider:

- What do the terms 'dying' and 'death' mean to you?
- What are your own experiences of dying and death and do these create positive or negative feelings for you? Why?
- What is meant by 'quality of life'?
- What role does the person's family or support system play during the palliative care period?

CONTEXT AND DELIVERY OF CARE

When you are on a clinical or fieldwork placement, you may be involved in palliative care as a specialist provider, a generalist provider or a support services provider. Each of these services can be delivered in a hospital, home, hospice or residential aged care setting (McNamara & Rosenwax 2007). You may find that people who are dying move between these settings as the trajectory towards death nears (for example, home to hospital or hospital to a residential aged care facility). Specialist palliative care providers are medical, nursing and allied health staff who have either significant experience in the area and/or have undertaken specialist study in palliative care as opposed to generalist palliative providers who work with people requiring palliation but do not have specialist training or experience (for example, primary care providers, general practitioners). Support services providers enhance the person's quality of life by providing emotional, spiritual or other services such as those provided by chaplains, welfare workers, volunteer carers and others.

Before you commence your placement, it would be worthwhile understanding the unique contribution that each of the team members can provide to the person requiring palliative care. For example, the occupational therapist might talk to the dying person about what he or she would like to accomplish with respect to self-care, social life, intimacy, leisure and productive occupations. This might include the provision of equipment and home modifications so the dying person can remain at home, management of symptoms such as fatigue, anxiety, depression and acceptance of impending death; pressure care, relaxation therapy, alternative methods for pain management, realistic goal setting, time management, and support and education for the carer (Keesing & Rosenwax 2011).

THE TEAM APPROACH

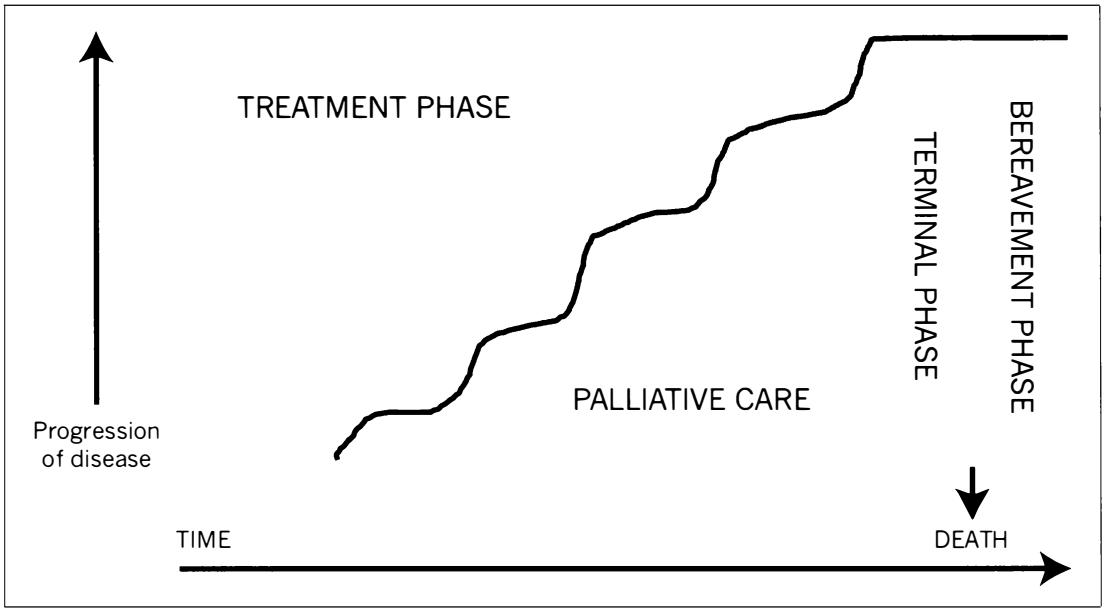
Palliative care utilises a team approach to address the needs of patients and their families. It cannot be achieved by any one health professional working in isolation. Traditionally, the palliative care team would include health professionals from nursing, medicine, social work, occupational therapy and psychology. More recently, the palliative care team may access the services of speech pathology, dietetics, physiotherapy and other health professionals to provide a rehabilitative approach to care in order to enhance the quality of life of the person who is dying.

THINK AND LINK

Chapter 8 is all about interprofessional practice. This chapter covers professional stereotypes and the importance of collaboration in teamwork in healthcare.

Palliative care sits comfortably within an interprofessional education and practice framework. It can be delivered early in the disease or **illness trajectory** and may be delivered in conjunction with chemotherapy or radiotherapy (see Figure 13.1). Ideally, health professionals would be involved throughout the disease process as well as during the palliative period. Importantly, bereavement care must also be offered to families as part of palliative care prior to and following the death of the person.

Figure 13.1: Appropriate care near the end of life



Source: Adapted from Lynn & Adamson 2003, in Murray et al. 2005

SPECIALISED SKILLS REQUIRED FOR THE PALLIATIVE CARE SETTING

The communication strategies required of students in the palliative care setting consists of a range of different verbal and non-verbal interpersonal skills. These skills are required from the very first contact with the dying person and their family or carer. You should aim to establish rapport with the dying person, their family/carer as well as initiating contact with other members of the healthcare team. Communication is not only about using verbal skills, but a range of non-verbal and interpersonal interactions including using appropriate body language and eye contact as well as consideration of the environment. You may need to modify your communication strategies with people according to their personal and cultural preferences. For example, families from a Muslim background may prefer that bad news is not passed directly to the dying person, women may choose to be cared for only by health professionals who are also women, some Muslims do not like their head to be touched, and it is important not to use your left hand when touching a person or giving materials to that person (Queensland Government 2011). Documentation in the medical notes, discussions with other members of the team and ongoing contact with the dying person's family members/carers are also essential for satisfactory care.

THINK AND LINK

Chapter 14 is about working in diverse settings. This chapter adds further to the discussion on consideration for the client's personal and cultural preferences.

The palliative period may be regarded as a very private and personal time in a person's life. However it can be distressing and sometimes unexpected and the dying person may feel as though they have a loss of control and few opportunities to make their own decisions affecting care. A key element of communication during this period is that the dying person's cultural and personal ideas about dying and death are considered. Australia is home to people from a wide range of countries across the world, where dying and death are viewed and managed in different ways. It is important to recognise this and modify your practice and communication accordingly. Students need to request assistance and support from their supervisor when working with families from culturally diverse backgrounds, so that suitable communication strategies may be implemented. There are many resources that may assist students to prepare for working with people from a range of different cultures. In addition, it may be appropriate to organise an interpreter or family member who knows the person well to assist with communication, so that care can be directed according to the person's wishes.

REFLECTION

- List the people from a variety of cultures that you might expect to see living in the area where you are undertaking your placement, for example, Muslim, Maori, Noongar Aboriginal and Jewish.
- For each of these cultures, consider their attitudes towards treatment of pain and symptoms, traditional versus 'western' practices, reliance on carers and involvement of health professionals.
- Consider the language, communication style, customs, and values, attitudes towards dying and death and traditional practices around funerals, bereavement and burial for these groups.
- Determine how you may need to modify your practice and communication to work effectively with these individuals and what resources are available to assist you.

Communication within the treating healthcare team is essential to ensure all members are aware of the client's condition, goals of treatment and expectations for care. Adequate preparation needs to occur prior to meetings with other professionals, the dying person and their family. Preparing questions/points to discuss will assist you to feel prepared for this contact and opportunities to discuss with your supervisor should also be utilised. Additional considerations must include the impact of pain and symptoms associated with the illness as well as any the presence of any comorbid conditions. A person who is experiencing pain and other distressing symptoms will not usually be able to participate in extended discussions with you and may need to reschedule for a more suitable time.

Regular communication with your clinical supervisor is essential. Students need to schedule regular opportunities to discuss and reflect on each contact with the dying person and their family to determine what went well, what didn't go as expected and to determine possible plans for future care. This will assist your learning and development and enable you to meet the learning outcomes for the placement. Clinical supervisors may have different supervision styles and regular contact/discussion with you will also enable them to monitor their own supervision styles and methods. Being able to communicate

effectively with the dying person and their family is essential to assist decision-making and to facilitate choices throughout the palliative phase. Effective communication also relies on an empathic and person/family centred approach where the dying person and family/carer plays a key role when making decisions about symptom management, place of care and place of death (Keesing et al. 2011).

CASE STUDY

David

David was 45 years old and lived alone. He was working in the public service when he was diagnosed with a malignant tumour of the stomach and oesophagus. Active treatment (chemotherapy) was provided up until one month prior to David's death. David was a very private person who didn't want to bother anyone and felt he could manage his condition without assistance. David's sister Leanne would visit every few days to assist with meals, shopping and house cleaning. Three days before David's death, his specialist contacted the community palliative nursing service to set up a visit. David was home when they visited for the first time, but was sleeping so didn't hear the door. A card was left in his mail box. When Leanne visited a few days later, she found David had died the day before.

QUESTIONS

1 Do you think David received satisfactory care in the month prior to his death? Why/why not?

2 What strategies or services do you think may have assisted David and Leanne to manage the palliative period of care effectively?

3 What unique contributions could you have made to assist David and Leanne?

SOME CHALLENGES OF WORKING IN PALLIATIVE CARE

There are many challenges associated with working in palliative care. Many students may have had limited exposure or opportunity to work with people who are dying, or even exposed to death and dying in their personal lives. While some students may have experienced the death of a family member or friend, it is not always an 'expected' death. This may be very different to working in palliative care, where there may be a period of time leading up to death. However, you may still feel unprepared for the range of intense feelings occurring as a result of the dying experience. Emotional responses may range from sadness, crying, not wanting to engage with others or withdrawal to acceptance as death being the expected and normal outcome of the palliative care continuum. All of these reactions are normal, but need to be considered in context. Talking and 'debriefing 'with your supervisor is an essential part of the learning process.

Many health professionals practise within a 'rehabilitative' framework, where improvement in the person's health and wellness is expected. When working with a person

who is dying, a very different framework may be employed and the outcome for the dying person is not about becoming well. This can be a difficult concept to work within and one which takes much discussion and reflection for the student. Timeframes may also be difficult to work with—there is often a short amount of time to build rapport with the dying person and their family/carer, as well as limited periods of time to plan and deliver services. The person's place of death may not have been decided and this often relies on rapid responses and the organisation of care may need to occur very quickly.

The dying person may have previously engaged a wide range of services and supports. This is usual for people who have experienced chronic disease and are now entering the palliative period of their illness. Examples of these people may include those with chronic heart and lung disease, progressive neurological disorders and Alzheimer's disease. Care of the person in these situations requires a comprehensive knowledge and contact with providers, carers and organisations that may have been involved previously. Individuals may have complex symptoms and pain for which they require a multitude of treatment approaches; medication, pressure care, nursing services, therapy, tests and other interventions.

Working with families and carers may also present challenges. The carer may have been caring for the person for months and years, and understand the person best and it may be difficult for them to accept assistance. Sometimes the carer is relinquished of their role if the person is hospitalised and this may also present further challenges for the healthcare team. For carers and families, managing unexpected events may cause anxiety and sometimes there may be conflict that causes communication difficulties. You may find that you draw upon many of your professional and interpersonal skills to manage these potential difficulties.

CASE STUDY

Jim and June

Jim and June had been married for 25 years and lived in a rural location. June was a school teacher and was diagnosed with motor neurone disease (MND) two years earlier. The couple often needed to travel up to four hours to obtain medical and diagnostic services. June experienced many symptoms as a result of her illness, but most recently experienced extreme fatigue, stress and anxiety and was hospitalised to try to manage these symptoms. June wanted to die at home, but the couple experienced many difficulties arranging this. Jim felt it was because the healthcare team did not believe that he could take care of June during the last few weeks of her life. June died in hospital three weeks after being admitted.

QUESTIONS

1 Use a reflective model such as Gibbs (1998) to analyse this case study (see below for further information about this model).

2 What might be your action plan if you were part of a palliative care team and were working with a couple like Jim and June?

3 What would be some of the reasons why a person would prefer to die at home and why might they want to die in hospital?

OPPORTUNITIES OFFERED IN PALLIATIVE CARE

Working in a palliative care setting may be seen as a privilege because many health professionals (including students) are not offered the opportunity to experience this part of healthcare. The palliative care setting provides many situations for the development of a range of highly complex clinical and interpersonal skills. In addition, these professionals may be welcomed as a part of the dying person's support network and assist them to make critical decisions about healthcare, place of death and to facilitate bereavement care for the family. For some health professions, particularly allied health, palliative care is viewed as an emerging area, a new field of practice and an opportunity for further research. Assisting a dying person to achieve a '**good death**' (Steinhauser et al. 2000) is a realistic aim for most families living in Australia and a well-resourced healthcare team can facilitate the achievement of this goal.

PREPARATION FOR PLACEMENT

There are many resources available that may assist you to prepare for your placement in a palliative setting. Palliative Care Australia is the peak body representing the ideals of individuals who strive for quality care at the end of life for all people. This organisation provides online resources, forums, professional development opportunities as well as publications to assist service providers, and consumers of services. The National Standards for the Delivery of Palliative Care are also provided on this website (Palliative Care Australia 2005). Adequate preparation may also involve an examination and reflection on your personal experiences of death and dying as well as a review of your own and other disciplines' roles and responsibilities within the healthcare team. In addition it is also good practice to discuss the expectations of the placement with your supervisor prior to commencement. Your own disciplines' representative organisation may publish useful information regarding the competencies required for working in the palliative care setting. Refer to Useful Websites at the end of this chapter for more excellent resources to assist you with your preparation.

REFLECTION

Research, define and reflect on the following common terms used in palliative care settings:

- Advanced care planning
- Clinical reasoning
- Cultural competence
- Disease trajectory
- Evidence-based practice
- Euthanasia
- Empathy
- Family-centred care
- 'Good death'
- Good enough death
- Illness trajectory
- Liverpool Care Pathway
- Living will
- Palliative approach
- Person-centred care
- Quality of life
- Terminal phase

REFLECTION

During your placement you will need to develop generic as well as discipline-specific competencies relevant to palliative care. We have started the list for you for generic competencies. Reflect on these and what they will mean for your practice in palliative care. Then, develop your own list of discipline-specific competencies.

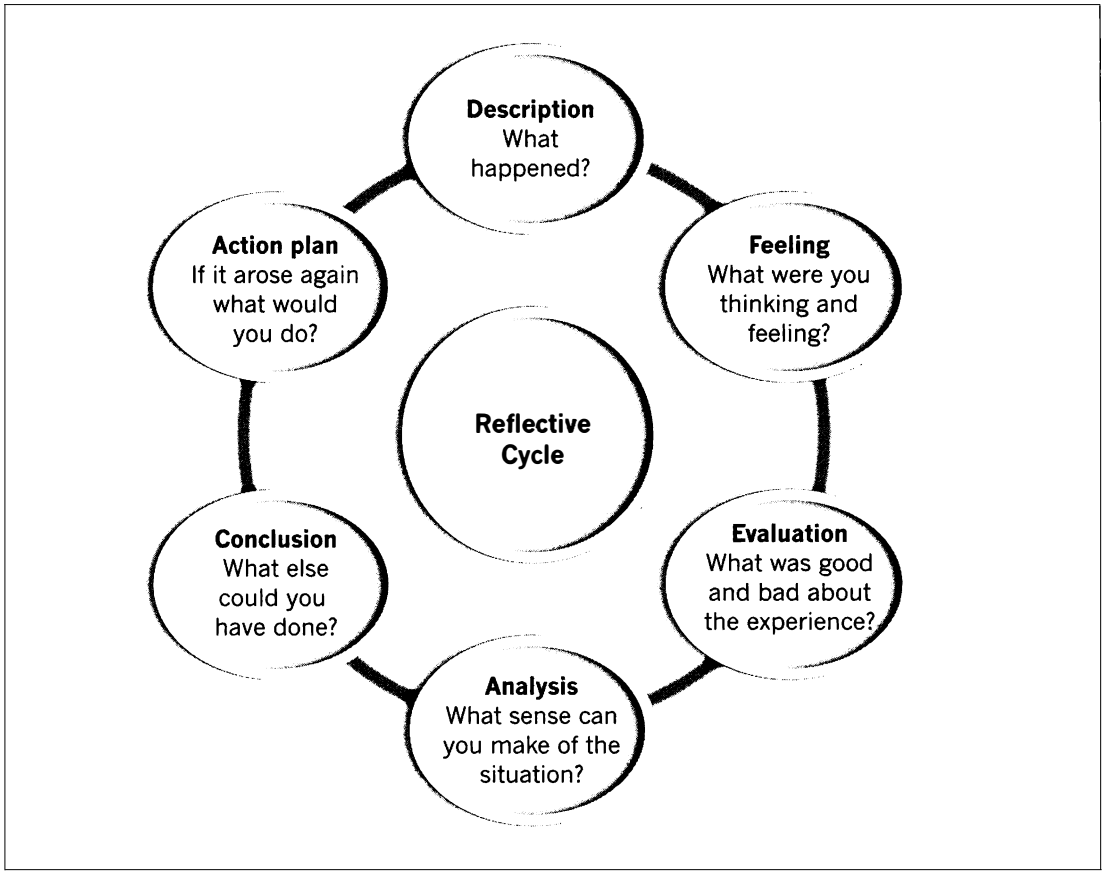
Generic competencies	Discipline-specific competencies
Empathic communication	
Client and family-centred care	
Documentation	
Interprofessional practice	
Regular contact with your placement supervisor	
Self-management	
Others	

DURING YOUR PLACEMENT

Undertaking a placement in a palliative care setting will most likely be physically and emotionally demanding, in part due to the types of illnesses and conditions you will encounter as well as exposure to a range of complex physical symptoms and psychological issues. These may be new experiences for you and may lead to a feeling of being overwhelmed. It is vital therefore to schedule time with your supervisor and/or fieldwork educator to discuss issues that arise as part of your placement. Using a reflective model such as Gibbs (1988) may assist you to understand thoughts, feelings and actions and help to prepare you for future work. Gibbs Model of Reflective Practice (1998) is just one of many tools that can be utilised to understand and learn from the many opportunities provided to you while working in palliative care. The model requires you to describe your thoughts and feelings about a particular incident, evaluate and make sense of the situation as well as determine further actions as a result of the incident.

Being aware of your own reactions to incidents, such as poor symptom management, uncontrolled pain or the death of a patient will assist you to develop strategies for managing future difficulties. Self-awareness is the first step towards understanding difficulties and should be utilised together with tools such as peer debriefing, discussions with your supervisor and practising stress management strategies. Following the completion of the placement you may also find yourself continuing to think about the placement as your experiences as a student help to shape your clinical reasoning for future practice.

Figure 13.2: Gibbs' model of reflective practice



Source: Gibbs 1998: 46

SUMMARY

Following a description of the environments in which palliative care is delivered, the chapter provides a range of resources around the context of care, communication strategies and benefits and challenges of working with people who are dying and their families. The chapter proposes that while there are profession-specific skills, competencies and attitudes required when working in palliative care, there are also many generic competencies common across all professions including reflective practice, client and family-centred care, empathic communication and self-management. These generic skills assist with interprofessional practices to ensure a **good enough death** (McNamara 2001).

Discussion questions

1 Fill out the Johari window in Chapter 5 answering the question 'If I worked in palliative care ...'. What have you learnt about yourself that you would be willing to share?

2 Discuss the roles that health professionals have in palliative care. What would be your professional role?

Portfolio development exercise: Considerations for a 'good death'

Consider the material you have read in the preceding chapter/s and read the case study below to answer the questions:

Mr Davison is a 65-year-old man living in a small community east of Derby in the Kimberley region of North West Australia (approximately 2500 kilometres by road from Perth). He is a member of the Baada tribe and lives with his extended family including his wife, four children and seven grandchildren. He was recently transferred by air to Perth and is currently an inpatient at Royal Perth Hospital. He is experiencing stage 5 (end stage) kidney disease and has been referred for palliative care by his specialist. You are a health professional, part of the treating team based at Royal Perth Hospital, and need to assist with Mr Davison's care.

1 What do you think Mr Davison would regard as a 'good death'?
2 What are the essential factors that you need to consider for Mr Davison to achieve a good death?
3 Who might be the key people involved in working with Mr Davison during the palliative period?
4 Are there any cultural considerations essential to Mr Davison's care? If you weren't sure what these might be, how could find out more about them?
5 What specific skills do you feel are essential to effective communication with Mr Davison and his family?
6 What recommendations would you make to other students working in this context to assist them in their preparation for working in palliative care as well as how to make the most out of the placement?

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USEFUL WEBSITES

Cultural Diversity: www.culturaldiversity.com.au

Department of Health and Ageing: www.health.gov.au

Dying Matters: www.dyingmatters.org

Palliative Care Australia: www.palliativecare.org.au

PCC4U: www.pcc4u.org

PART 1 CHECKLIST

ISSUES FOR PRACTICE

The following points have been collated from Part 1 of the book. These checklists are organised under the competencies of: professional behaviour, ethical behaviour, communication, knowledge of discipline-specific assessment and treatment, lifelong learning and interprofessional practice (collaboration and working in teams).

Getting ready for placement

Professional behaviours (being organised, understanding workplace codes of conduct)

- ❑ I have found out the geographical location of my placement and know how to get there.
- ❑ I have completed all of the program administration needed to organise my placement.
- ❑ I have applied for my police check.
- ❑ I have applied for my Working with Children Check.
- ❑ I have compiled my curriculum vitae to take to my placement agency.
- ❑ I have accessed the agency annual report and/or information about the services of the agency where I will be going on placement.
- ❑ I understand the dress code for my placement agency and have appropriate clothing to wear during the practicum.
- ❑ I have a good idea of four or five learning objectives I hope to address on placement.
- ❑ I have discussed with my family and/or flatmates the extra work obligations and time commitments I need to meet while being on placement.

The three Rs: roles, rights and responsibilities

If I am working with any of the groups listed below, I require a pre-placement police check and a Working with Children Check (WWCC).

- ❑ Do I have mine?

I require such a check because the following groups are the categories of clients or patients where an unacceptable level of risk may exist if these clients are exposed to inappropriate persons:

- ❑ any person under the age of 21 years who is subject to an order of the court that relates to their welfare
- ❑ any person under the age of 18 years who is subject to a protective service notification, investigation or involvement
- ❑ any person who is subject to an order of the Children's Court or subject to guardianship, following a protection application
- ❑ any person under 18 years to be placed for adoption
- ❑ any person under 18 years who receives a residential or home-based care or other service funded through Protection and Care and/or Supported Accommodation and Assistance Program (SAAP)

- ❑ any person who is deemed an eligible person under the *Intellectually Disabled Persons' Services Act* 1986
- ❑ any person who receives a facility-based or in-home accommodation service funded under the *Intellectually Disabled Persons' Services Act* 1986
- ❑ any person who receives services for care or treatment of a mental illness, under the *Mental Health Act* 1986
- ❑ any person who receives services through an early childhood intervention program
- ❑ any person who receives services under the Home and Community Care (HACC) program
- ❑ any person who receives treatment through the School Dental Health Program, the School Nurses Program, the Tuberculosis (TB) Program and by a Sexual Health Centre
- ❑ any person defined as a patient under the *Alcohol and Drug Dependent Persons Act*
- ❑ any aged or infirm person who receives in-house services
- ❑ any person who receives public rental housing services
- ❑ any other such client or patient who receives direct care services and where in the view of the relevant manager there may exist an unacceptable level of risk by exposing these clients or patients to inappropriate persons.

Professional behaviours

I am aware of my responsibilities on placement, which are:

- ❑ Punctual and regular attendance at the placement venue.
- ❑ If absent during the fieldwork placement, I will notify the agency as early as possible, and will negotiate with their fieldwork educator how this lost time will be made up.
- ❑ I have identified a communication strategy with the agency; for example, an exchange of contact details between myself and the agency's fieldwork educator.
- ❑ I will notify the fieldwork educator of any circumstances likely to pose a risk to either myself or any of the agency's clients or staff; for instance, the presence of any infection or an inability to perform a certain task, such as lifting.
- ❑ I understand and will adhere to the dress code.
- ❑ I will locate and familiarise myself with local policies and procedures relevant to my role within the agency.
- ❑ I understand about maintaining confidentiality at all times.
- ❑ I am to communicate with staff and/or my fieldwork educator any incidents or issues that may be significant to the wellbeing of clients, patients or service users.
- ❑ I will report any injury on fieldwork placement or an accident to the immediate fieldwork educators. I will also notify the university as soon as possible, and lodge a report with the university.
- ❑ I will communicate with the university regarding any issues that may be significant regarding the fieldwork placement.
- ❑ I realise it is my responsibility to obtain feedback on my performance.
- ❑ I will ensure that the fieldwork educator completes the required evaluation and/or assessment requirements.

Further professional attitudes and behaviours I am aware of are:

- ❑ processes to clarify personal values because situations will challenge my values
- ❑ clarification of what I am responsible for and to whom I am accountable
- ❑ time management
- ❑ professional issues, including:
  - ❑ duty of care
  - ❑ occupational health and safety: self
  - ❑ occupational health and safety: others
  - ❑ ooccupational health and safety: environment; for example, infection control, lifting

I will also need to develop my written and verbal communication with:

- ❑ professionals and/or other team members
- ❑ service users, patients or clients
- ❑ the university.

Becoming a reflective practitioner

Professional behaviours and communication style

Taking the four levels of reflective writing put forward by Kember et al. (2008):

- ❑ I can write about a case using Habitual action/non-reflection.
- ❑ Then I can rewrite about the same case using Understanding.
- ❑ I can then write about the same case using Reflection.
- ❑ I can write about the same case using Critical reflection.

Models of supervision

Developing insights into professional behaviours and communication

- ❑ Reflect on the type of supervision that suits you best.
- ❑ How do you like to learn?
- ❑ Have you used critical reflection to explore a situation that occurred on placement?

Making the most of your fieldwork learning opportunity

I have reflected on my professional behaviours in relation to:

- ❑ my personal attributes
- ❑ my generational attributes
- ❑ my generic knowledge and skills
- ❑ my professional behaviours
- ❑ my discipline-specific knowledge and skills.

To make the most of my fieldwork placement I will:

- ❑ reflect on my practice; seek appropriate advice; set goals and take action
- ❑ use the practice window when I need to.

Assessment of clinical learning

Assessment can identify which areas of knowledge and professional behaviours need more input:

- ❑ Have I read the assessment criteria and assessment form before taking up my placement?

- ❑ Have I reflected critically upon the means by which I will be able to demonstrate my achievement of competencies?
- ❑ Am I able to link different competencies to activities I will carry out on placement?
- ❑ Have I planned to rate myself on the assessment form before meeting with my clinical educator?
- ❑ Have I established what the minimal standard of performance looks like?
- ❑ Do I have a plan for managing any mismatch between my self-assessment and that of my fieldwork educator?
- ❑ Have I spoken with my fieldwork educator about how I should progress throughout my placement?

A model for alternative fieldwork

Professional behaviours and generic and discipline-specific knowledge:

- ❑ I am clear on the aims for my fieldwork.
- ❑ I realise that my host fieldwork educator is not from my profession and I need to respect this.
- ❑ I will aim to learn how to articulate to others what my profession does and what my role is.
- ❑ I will actively seek out support from peers, mentors, discipline-specific staff and host staff.

Interprofessional learning in the field: multidisciplinary teamwork

This chapter is all about the competence of interprofessional learning. To assist in developing this competency some advice for success is:

- ❑ start establishing a positive rapport with my fellow students by holding a face-to-face meeting, a teleconference or an online chat or asynchronous discussion forum
- ❑ exchange contact details and a little about my personal and academic backgrounds, including what I think is most important in IPL and any particular interest areas
- ❑ discuss logistical arrangements, such as travel and accommodation (if relevant), timetables, negotiation of shared learning tasks and any other concerns, issues or information that are still needed
- ❑ establish a positive working relationship by clarifying my expectations and hopes for the placement
- ❑ identify where my respective expectations and learning objectives are similar to and different from those of the other students
- ❑ discuss how I might manage to accommodate everyone's core goals, and where I am prepared to make compromises
- ❑ be aware of my own professional stereotypes
- ❑ make sure I know what to do if things go wrong, such as personal health or safety issues, or if the placement is not meeting my expectations.

Learning from failure

This chapter touches on all competencies as failing can impact on all competency areas.

- ❑ Am I having difficulties?
- ❑ Do I think I am failing?
- ❑ I will discuss my concerns with my fieldwork educator before my midway assessment.

Using digital technology for knowledge transfer

Life-long learning, discipline-specific knowledge, professional behaviour and ethical behaviour online as well as communication are all competencies that underpin this chapter.

Professional behaviours and attitudes and communication

- ❑ I have checked my online presence to ensure it is professional.
- ❑ I have untagged any photos of me that do not show me in a professional light.

Discipline-specific knowledge, communication and lifelong learning

- ❑ I am aware of online technology where I can network and share professional knowledge.
- ❑ I know to be aware of sites that are evidence based.
- ❑ I am aware of online technologies I can use to help organise information.

Fostering partnerships with action

Professional and ethical behaviour and communication competencies were mentioned in this chapter. These competences could be aided by:

- ❑ accessing and reading the fieldwork agency's or facility's annual report
- ❑ making a mind map (using an illustrative diagram) of the key real-world issues for each of the stakeholders involved in your fieldwork placement
- ❑ accessing a copy of the contract (if there is a current document of this kind) that your university has with a major provider of fieldwork placement. Identify your responsibilities and those of the other stakeholders.

Supporting people's decision-making

The competencies of professional and ethical behaviours, communication and interprofessional practice underpin this chapter. This chapter presented some tools to assist with ethical decision-making. These are:

- ❑ The doughnut model (Handy 1994) (Figure 12.1): Is the presenting issue a core responsibility or one for which I need to use my judgment?
- ❑ The person-centred risk assessment (Kinsella 2000) (Figure 12.2): What are the risks involved?
- ❑ The supported decision-making model (Watson 2011) (Figure 12.3): Listening to get a consensus view with the patient/client, family and other health professionals and care workers.
- ❑ Decision-making pathway (Watson 2009) (Figure 12.4): I can use this when professional duty of care, risks and competence may have an impact on decisions to be made about, with or for a person.

Working in palliative care

The competencies of communication, interprofessional practice, and ethical and professional behaviours underpin this chapter.

Professional behaviours

- ❑ What are my attitudes to death and dying?
- ❑ How are my attitudes influenced by personal, family and cultural perspectives?
- ❑ Would I be open to accept another perspective?

Communication and interprofessional practice

- ❑ Do I understand who is on the palliative care team in my current placement?
- ❑ Do I know what each person contributes?
- ❑ What can I contribute to the team?

Part 2

Contexts of Practice

Most tertiary institutions endeavour to offer their students a broad fieldwork experience by giving the same student several placements throughout a course. This section provides information on a variety of clinical fieldwork placement settings, and how to prepare for each. For the second edition, we have also added a fieldwork clinical supervisor perspective through a vignette. In each of the ten chapters you will be introduced to what you need to prepare for each setting, what you might expect, the type of competencies that are needed and the type of knowledge you are likely to develop over your fieldwork placement in that setting. Fieldwork clinical placements introduce you to the complexity of practice in your health field. We hope you enjoy the experience.

CHAPTER 14

Working in Diverse Settings

Sharleen O'Reilly

LEARNING OUTCOMES

After reading this chapter you should be able to:

- understand the structure of the healthcare setting in Australia
- define some key elements involved in successful orientation on placement
- understand the meanings of cultural awareness and cultural competence
- work with interpreters.

KEY TERMS

Confidentiality
Cultural competence
Interdisciplinary team
Medicare
Person-centred care
Pharmaceutical Benefits Scheme
Superclinic

INTRODUCTION

Starting any work-integrated learning can be a time of change and transition. It may be the first time that you will enter your future work environment, your first exposure to working with clients or even be your first time entering a healthcare setting in Australia. The result can be high levels of anxiety, stress and uncertainty. The aim of this chapter is to help you adapt to diverse workplace settings through addressing common issues faced by students within these environments.

THE AUSTRALIAN HEALTHCARE SYSTEM

Overall structure

Understanding the Australian healthcare system relates to knowledge competencies and this competency would be expected in the early stages of your course. Australia has two levels of government (state/territory and federal/Commonwealth). This division affects the healthcare system and the way that it is run. The Commonwealth government has responsibility for policy setting and budget allocation for the whole of Australia. The states and territories are largely responsible for the delivery and management of the healthcare services. Under new legislation, the Commonwealth will fund half the healthcare service provision to ensure national standards of care are maintained.

Healthcare services include acute and psychiatric hospital services and other public health services, such as dental health, school health, environmental health, maternal and child health programs. The Commonwealth funds most health research and medical services outside the hospital setting. Aged care is divided into two main areas: residential (such as accommodation provided by nursing homes or hostels) and community care (such as services provided in the form of delivered meals, home help or transport). The funding and delivery of aged care has recently been taken over by the Commonwealth to improve service coordination and planning. Both public and non-government (mostly religious and charitable) organisations provide community care services, under the Home and Community Care (HACC) Program, which aims to keep individuals independent of residential care and out of hospitals through increased provision of services to at-risk persons.

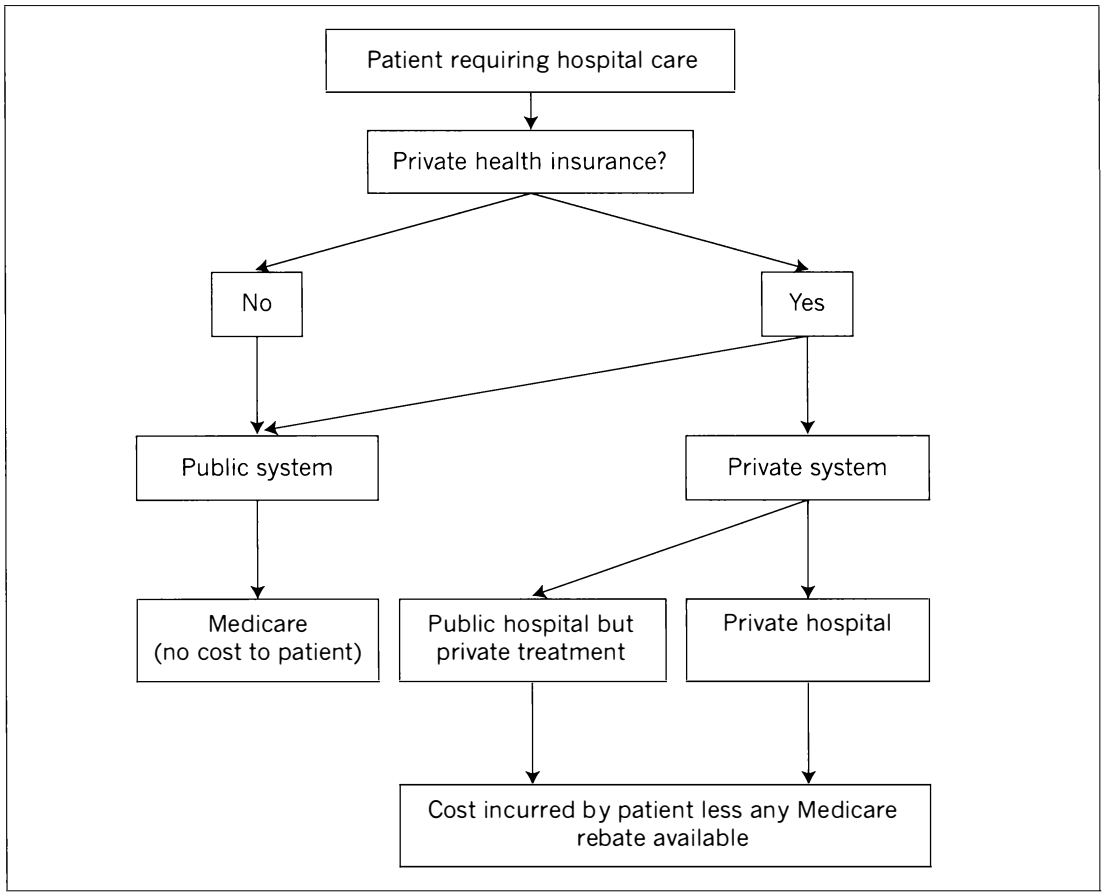
The Australian Red Cross is funded by both Commonwealth and state governments to operate the Blood Bank and organ donation system. Because of the vast size of Australia, several specialised services, such as the Royal Flying Doctor Service (delivering care to remote areas by aircraft), Aboriginal and Torres Strait Islander peoples community-controlled health services (providing for Indigenous-specific health needs) and Regional Health Services (providing for community-identified priorities in health and ageing services), funded by state and federal governments, reach out to regional and remote communities.

Public hospitals

The public health system in Australia is called **'Medicare'**. It allows for public hospital services to be provided at no cost, substantial reductions to the cost of prescription medicines (with a safety net providing free medicines for the chronically ill) and free or subsidised treatment by doctors, and some optometrist and dentist services. Medicare covers all people residing in Australia who are Australian citizens, New Zealand citizens or holders of permanent visas (see Figure 14.1). Local Hospital Networks are responsible for the organisation and funding of public hospitals.

Most public hospitals provide **acute-care** beds and emergency outpatient clinics with those in urban areas generally providing a more complex level of care, such as organ transplant, burns management paediatrics and specialist services. Independent centres for the provision of same-day outpatient surgery and other procedures, such as endoscopy, are mostly run privately, although public hospitals may also provide these services. Unlike other countries, Australia has no system of unique patient identifiers. Each hospital allocates

Figure 14.1: The Australian hospital system: A patient perspective



a unique record number (URN) to each patient, and this number varies from hospital to hospital, making tracking of patient records difficult between sites. Pathology and diagnostic imaging is also predominantly privately run. Mental health has historically been operated separately from other healthcare services, but the Commonwealth has recently invested in integrating mental health back into the mainstream healthcare system and improving service provision.

The private system

Australia has a strong private health sector accessed through having private health insurance. Individuals with private health insurance choose how they access the healthcare system: they can remain within the public system or elect to be treated privately. Public hospitals will charge patients private fees and a portion of the medical inpatient fees if they want to access a treatment through a doctor of their choice or have specific accommodation, for example, their own room. Private hospital access is the other option available to those with private health insurance. These hospitals can be run by commercial or not-for-profit organisations, such as religious bodies, or private health insurance funds. Private health insurance can also be used to cover allied health services and some medical appliances such as hearing aids and glasses.

Community-based health services

Community-level healthcare is delivered mainly through health centres, which generally provide a variety of services, from general practitioners, allied health professionals (such as social workers and physiotherapists) and nurses. People who access community-level care are commonly referred to as 'clients', reflecting the fact that individuals are actively involved in their own care. Medicare Locals are the newly organised centres responsible for the funding and organisation of primary healthcare services in Australia.

Community-level healthcare also has a health promotion focus, and may be part of a Primary Care Partnership (PCP) within a region. PCPs were formed to make health promotion work more effective within the region where healthcare centres are located, and to offer a coordinated approach to meeting the health needs of the communities they serve, but this may change under the new Medicare Locals structure.

Superclinics are part of the Medicare Local initiative providing a raised level of healthcare services within one location, often offering longer opening hours and additional healthcare providers/services such as onsite pharmacies, pathology labs and radiography.

The Medicare system allows for the cost of non-hospital healthcare to be either fully reimbursed or substantially covered. Patients can choose to pay for the service upfront and apply for a rebate of the 'gap' through Medicare offices; or, where 'bulk billing' is offered, the service bills Medicare directly, so there is no out-of-pocket expense for patients when they receive the service.

Prescription medicines dispensed in the community receive a direct subsidy from the Commonwealth through a scheme called the **'Pharmaceutical Benefits Scheme' (PBS).** All public hospitals provide medicines free of charge. There are two categories within the PBS: concessional (war veterans, pensioners, certain disadvantaged groups) and general; the difference is that a smaller 'gap' amount is paid by the concessional group.

REFLECTION

THE AUSTRALIAN HEALTHCARE SYSTEM

1 What is your experience with the Australian healthcare system, either as a health professional or as a patient or client?
2 Do you have any experience of healthcare systems in other countries?
3 What do you think are the major benefits and drawbacks of the Australian system from the perspective of a health professional and a patient or client?

ORIENTATION TO NEW SETTINGS

Entering a new environment is always a time for increased anxiety and uncertainty. The most important point to remember is that you are going on fieldwork placement as a student and you are not expected to know everything in your first week! Your fieldwork placement will give you the time to develop your skills and knowledge in a practical environment,

and your fieldwork educator will be there throughout your placement to provide you with support and guidance.

Important points to remember are:

1 *Ask for help*: Ask for help—communicate in getting directions, advice or finding out someone's name. Aim to use any resources that you have to hand, for example, a student orientation manual. Ask a fellow student, or if that fails, ask staff members, as they will usually respond positively and can remember what it was like to be unfamiliar with their workplace. Staff may be less inclined to help in situations where the same questions are asked repeatedly, when questions are posed at inappropriate times or where the answer is easily available.
2 *Observe, observe, observe!* While on fieldwork placement, take time to observe and remember names, faces and positions, as well as department names, services and the roles held within them. This can help orientate you to your new setting and the people you will be working with.
3 *Record*: Keep a diary or notebook with you. It can be used to write down any learning issues you encounter, jot down any questions you have for your supervisor or keep lists of important information within reach. Write your daily to-do list, or simply use it as a reflective tool to help process your experiences on placement. In this way you build up awareness of professional behaviours.
4 *Read*: Most orientation processes involve a fair amount of reading, as you will need to become familiar with the placement site procedures and policies. Although this can be overwhelming and boring to do, it will pay dividends when you actually start interacting with patients or clients and the interdisciplinary team, and as you gain more confidence about how the placement site works and care is administered. Each placement site operates differently, including such aspects as medical record-keeping and storage, admission and discharge procedures and mealtime and workplace norms, such as start and finish times, meal break allocation and reporting illness procedures.
5 *Communicate*: A key to a successful placement is maintaining open communication channels. Both you and your supervisors need to be aware of your learning goals and how you are progressing with them. Supervisors are not mind readers! You will need to express your fears, concerns or needs as 'I' statements, then express preferences as possibilities, not as if they are the only option. Negotiate together the possible options to arrive at the best possible outcome, and act in a responsible manner while working through them, rather than blaming others for any issues that arise. Regular meetings and clear learning goals are core aspects to a successful placement and open communication (Cleak & Wilson 2007: 26–7).
6 *First impressions*: As you enter a workplace, remember that first impressions do last. Your appearance will reflect on your profession, even though you are still a student. Most fieldwork placement sites will have a dress code that will include either a uniform or required standard of appearance in conjunction with appropriate identification of who you are. *Smart casual* is the term commonly used: don't wear jeans or revealing clothing. Look at how your supervisor and peers dress for guidance. Is the way you are dressed a good reflection of how you would like to see a health professional dress if you were a patient or client? Comfortable, enclosed shoes and clean, ironed clothes, in conjunction with a neat appearance (tidy hair, makeup and jewellery), can help make your first impression with patients and co-workers a positive one.

7 *Confidentiality*: While you are on placement you will have access to sensitive, personal and privileged information. It is your obligation as a healthcare professional to respect that the information was provided in confidence, and should not be shared unless consent is given by the patient or client. Patient information or experiences should not be used as conversation pieces, and any notes taken for learning purposes should not contain identifying information. They should be kept for your use alone, and disposed of correctly.

THINK AND LINK

Confidentiality is an important concept to understand throughout your fieldwork experiences and in professional practice. Maintaining confidentiality is part of ethical behaviour. Consider Samuel's actions on his first day of placement: see the case study following.

CASE STUDY

Samuel the dietitian's first day on placement

Samuel is a student dietitian on his first placement in a large teaching hospital. He has arrived on his first day a bit late and tired from working the previous evening in his part-time job. His fieldwork educator is in charge of a busy gastrointestinal ward, and has already left for the early morning ward round. She has given a list of possible procedures for a colleague to hand to Samuel. He should observe these procedures either that morning or afternoon. He also needs to read a folder on the policies and procedures of the dietetic department. Samuel is keen to experience what the workplace has to offer. Later that morning he volunteers to observe a nasogastric feeding tube being placed. Reading the policies and procedures is the task he has elected to do that afternoon, provided he has time.

The placement of the tube was a success and the patient was able to start feeding. Samuel found that the whole experience helped him see the relationship between the process of placing a tube and the dietitian's role of providing adequate nutrition to the patient. He is keen to share this experience with his peers. When he meets one of them in the elevator, he describes the event in detail, including the ward and patient's name.

QUESTIONS

1 What are the areas of concern about Samuel's first day?
2 What could Samuel have done differently to improve it?
3 What could his supervisor have done differently to improve it?

INTERDISCIPLINARY TEAM

In Australian healthcare settings, the **interdisciplinary team** is seen as the key unit within a 'person-centred' care environment. **Person-centred care** involves recognising the person's freedom to make his or her own decisions; it is a holistic view, with the patient or client at the centre of all care decisions. The interdisciplinary team approach acknowledges the

diverse skill base and understandings that each profession offers when caring for patients or clients. It seeks to use these in the most effective manner possible to achieve the best possible health outcomes for the patient or client. A variety of members may make up a team. Table 14.1 outlines some of the team members you may encounter on placement, as well as their levels and roles.

Table 14.1: Interdisciplinary team members

Title	Levels	Role
Nursing staff	• Student • Enrolled nurse • Registered nurse (RN) • Midwife • Nurse practitioner • Nurse manager	Primary care delivery to patients or clients. Students and enrolled nurses are not registered to practise independently. Midwives are trained in the care of pregnancy and birth. Nurse practitioners have advanced training in specialised areas. Nurse managers are generally responsible for the running of a ward or unit and the nursing staff within it.
Medical staff[1]	• Intern or student • Resident • Registrar • Senior registrar • Consultant	Responsible for primary care of patients or clients. Interns or students are not registered to practise independently, and are supervised. Residents are registered to practise independently. Registrars are registered medical staff training in a speciality area. Consultants are fully registered specialists with the ultimate responsibility for primary care of patients or clients within their speciality area, and manage the medical staff under them.
Care assistant		Supporting the care of patients or clients in roles possibly delegated by nursing staff or other healthcare professions, for example, attending to personal needs of patients, moving patients or equipment, or collection and distribution of food orders.
Technician		Involved in the provision and running of specialist equipment or services, for example, sterile supply, anaesthetic assistance, cardiac monitoring.
Healthcare worker		May function independently or as part of an interdisciplinary team. Various roles can be undertaken; for example, that of an Aboriginal healthcare worker.
Social worker[2]		Responsible for linking of patients or clients with social supports available such as housing or Centrelink (government support services).
Dietitian[2]		Responsible for the provision of adequate nutrition and nutrition education to patients or clients.
Physiotherapist[2]		Responsible for patient or client care and education in the areas of mobility, rehabilitation and ventilation.

Title	Levels	Role
Occupational therapist[2]		Responsible for therapy involved in recuperation from injury or disease and performance of activities of daily living such as washing, dressing, eating and hobbies.
Podiatrist[2]		Responsible for assessment and treatment of feet and associated conditions.
Speech pathologist or therapist[2]		Responsible for study and treatment of speech, communication, language and swallowing problems.
Psychologist[2]		Responsible for assessment and treatment of mind and behaviour problems.
Counsellor		Responsible for supporting patients or clients in dealing with personal and non-psychological problems.

Source: Table by Sharleen O'Reilly, 2009, adapted from Levett-Jones & Bourgeois 2007: 36–8

[1] The level of medical staff present in different healthcare settings will vary. For example, some private settings will only employ consultants and senior registrars, whereas other settings can be training hospitals, which will have interns through to consultants.

[2] Students require supervision and are not qualified to practise independently.

REFLECTION

WORKING IN TEAMS

When learning about interdisciplinary teams, some activities that will help facilitate your learning are:

- attending team meetings where possible, as they give you real insight into how the team works
- becoming familiar with how different staff roles interact within different teams
- developing an understanding of how the team communicates and works together to provide patient-centred care.

THINK AND LINK

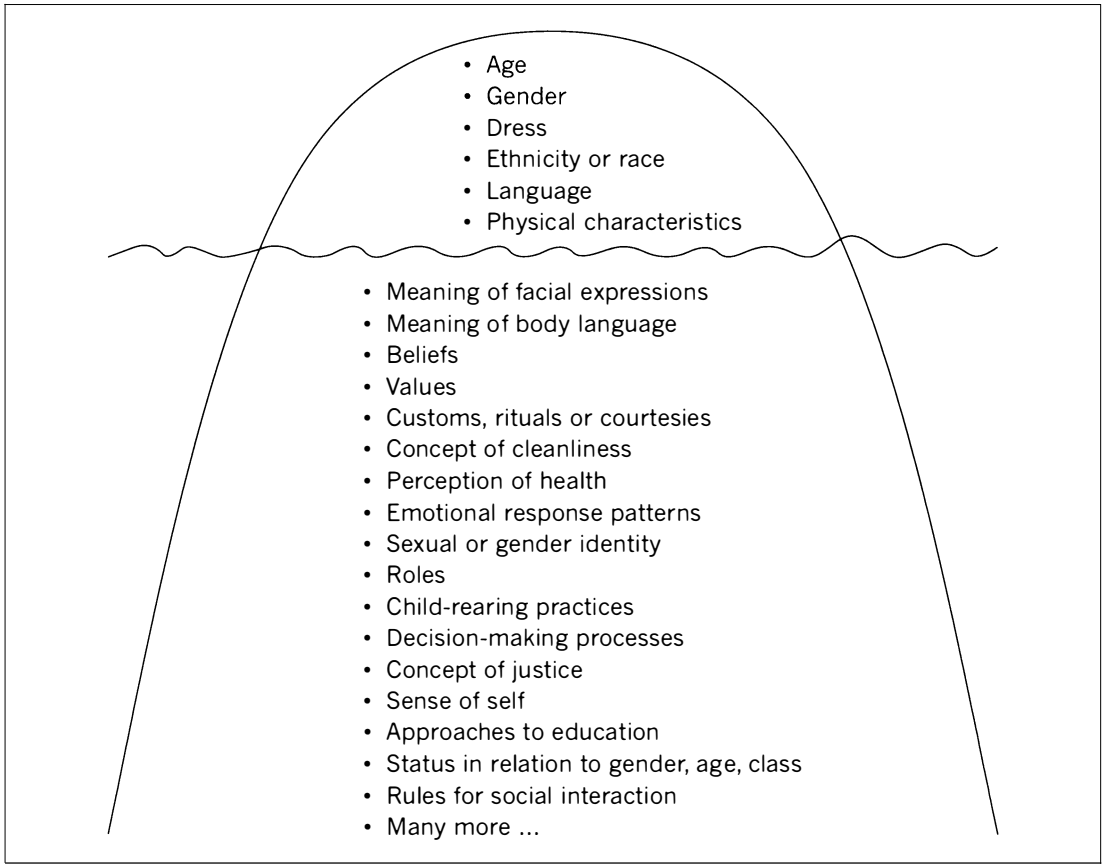
Chapter 8 is about interprofessional education and interprofessional practice. This chapter will give you information that you could use in the Reflection above. Chapter 8 also uses concepts of cultural competence, and Table 8.4 from this chapter could be read in conjunction with the section below.

DIVERSITY AND CULTURAL COMPETENCE

Australia is a diverse country, especially in terms of culture. This presents its own challenges to the student. Culture is a loose term for the patterns of human behaviour exhibited by social or ethnic groups, allowing them to identify as a unique group. The iceberg concept of culture is shown in Figure 14.2. It illustrates that the visible portion of a person's culture is only a small part of what is actually below the surface.

Cultural competence is defined as 'the demonstration of knowledge, attitudes and behaviours based on diverse, relevant, cultural experiences' (Schim et al. 2005: 355). To work in a culturally competent manner, it is important that you become culturally aware. The first step in this process is to look at your own cultural background, so that you can have insight into how this affects your view of the world around you. Then look at your peers, notice how diverse their cultural backgrounds are, and learn from them about their cultures (Baird 2008: 105–8).

Figure 14.2: The iceberg concept of culture



Source: Adapted from the National Center for Cultural Competence 2005

SUPERVISOR PROFILE

NORAH HOSKEN

Norah is a social work educator with an extensive background in social work practice, supervision and liaison experiences across three states in urban, regional, rural, remote and international contexts. Her area of expertise has been in fostering the development of social work in its interrelated components of education, practice, supervision and liaison to work more effectively across similarities and differences, particularly with highly discriminated against peoples.

1 *Tell us about your role. What does a typical day involve?*
I am a social work educator with an extensive background in social work practice, supervision and liaison experiences across three states in urban, regional, rural, remote and international contexts. My area of expertise has been in fostering the development of social work in education, practice, supervision and liaison to work more effectively across similarities and differences, particularly with discriminated-against peoples. Currently, I am the Bachelor of Social Work Field Education Coordinator at a regional university with a large off-campus cohort of distance enrolled students who undertake placements across diverse geographical and socio-demographic areas in Australia, and internationally. The two placements, each of 70 days duration, required by our professional body, the Australian Association of Social Workers (AASW) provide students with experience across two fields or modalities of social work practice. I oversee the overall organisation of the placements to ensure quality of experience and supervision. In addition I chair the two social work units of study that frame the placement experience and facilitate student's integration of theory with practice via face-to-face or online seminars and weekly online reflective discussions across key areas of social work practice.

2 *What are some of the challenges you face as a clinical supervisor?*
A key challenge facing social work educators, supervisors and students is how to co-create social work learning environments that adequately respond to the dynamic nature of our increasingly diverse societies. A primary motivation for improving our education, placement and supervision practices is that it results in better services for clients (Morrison & Wonnacott 2010). In the busyness of placement pressures, I think the ability to see how our own behaviours as a staff member (university or agency) or student might detract from the quality of learning and then ultimately detract from service provision for vulnerable people is easily lost. This challenge, then, involves two processes. First, it requires educators, students, supervisors and liaison staff to learn about and work across their own similarities and differences in terms of race/ethnicity, gender, dis/ability, religion, class, sexual orientation, geographic location, roles, organisational contexts and power differences. Second, in learning and doing this process we then develop, model and practise the knowledge, skills and attitudes needed to underpin practice with service users across similarities and differences. If we as educators, fieldwork supervisors and liaison staff cannot 'do it' ourselves, it seems unreasonable to expect students, who are generally in a

less powerful position, to magically deliver practice that is aware of and responsive to diversity.

3 *What is unique about this setting in terms of student supervision?*
A major revision to the Australian Association of Social Workers *Code of Ethics* (AASW 2010) now requires culturally competent practice and commits 'social workers to acknowledge and understand historical and contemporary Aboriginal and Torres Strait Islander disadvantage and the implication of this for social work practice'. Culturally competent practice focuses on 'systemic, organisational, professional and individual levels'. These are positive but challenging developments for many social work supervisors, educators, practitioners and students. The AASW *Education and Accreditation Standards* 2008 updated June 2012 prescribe cross-cultural (AASW 2009) and Aboriginal and Torres Strait Islander (AASW 2012) curriculum content for social work qualifying courses. The Practice Standards for Social Workers (AASW 2000) are currently under review. These changes are significant for social work education, practice and supervision.

4 *What clinical skills are important for this setting?*
Being guided by an ongoing personal/professional process of working towards 'cultural humility' (Tervalon & Murray-Garcia 1998) utilising critical awareness (Furlong & Wight 2011: 39), informed not knowing (Laird 1998) and mutual respect inquiry (Hosken 2010) are consistent with an anti-oppressive approach. This approach for working with similarities and differences does not prescribe definitive skill sets. Social work educators, students and practitioners need to learn with, and respond to, the worldview and knowledge of the client, family and community they are working with to understand how to choose or learn relevant ways of having meaningful and purposeful discussions. These are some of the micro-skills that may be relevant depending on the context and as seen as useful by service users:

- 'Deep, Respectful Listening, and Stillness' (Bennett et al. 2011: 28): An essential element is the use of silence with minimal questioning and interruption.
- Culturally friendly attitude (Engelbrecht 2006) using mutual respect inquiry (Hosken 2010): This includes an awareness of our own social location and worldview that signals and invites interest in a reciprocal relationship with client, family and community.
- Cultural humility (Tervalon & Murray-Garcia 1998: 117): This involves a lifelong process of self-reflection and self-critique. The most serious barrier to culturally appropriate practice is not a lack of knowledge of the details of any given cultural orientation, but the worker's failure to develop self-awareness and a respectful attitude towards diverse points of view.
- Critical questioning: This involves exploring with the service user the historical, cultural and social functions of particular norms, rules or ideologies which are operating in their personal experience of a situation.
- Dialogical practice (Ife 2008): This involves the continuous cycle of putting theories into practice as co-understood in relation to our conversations and work with clients, feeding back this new co-created application of practice into

theory, and using this experience to help question and improve/build theories and practice the next time we work with a client.

- Universalising: Drawing attention to the links between experiences the client sees as unique and specific to them, and the experiences of others in the same situation. Requires social and personal empathy.
- Individualising: Recognising features specific and unique to the clients' situation that makes their feelings, thoughts and behaviours unlike those of others.
- Validating/normalising/de-guilting: Recognising the external, institutional social pressures (dominant ideologies, societal pressure, socialisation processes, lack of material resources, lack of money, labelling ...) that condition a person to think, feel and act in a particular way.
- Clear contracting: Openly acknowledging the contradictions and conflicts between what you would like to be able to do personally, what the client would ideally want from you and from the agency, and what the agency obliges you to do within the context of its mandate, constraints and requirements.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*

In preparing for first and final placements, on a general level, it is useful for students to research the agency contexts in which they will be placed. Having an understanding of the nature of the agency, its policy and practice contexts, and potential clients, enables students to review their course material to revise key resources and relevant practice approaches. To specifically prepare for diversity, I think it is useful for students to revise the key knowledge, skills and attitudes including:

- exploring and problematising key concepts and terms used to describe and enact anti-oppressive and anti-racist practice
- willingness to engage in lifelong learning to develop and deepen self- racial/cultural/ethnic awareness and complicity in unearned privileges and oppressions
- willingness to engage in lifelong learning to develop and deepen bicultural and multicultural awareness
- initial and ongoing development of understanding about social and historical construction of race, ethnicity and culture
- for those who identify with the dominant white culture genuinely engaging in efforts to identify and change white privilege at self, personal, cultural and structural levels (Thompson 2006) through processes including white awareness training (Ryde 2009)
- understanding how race/ethnicity intersects with other dimensions of oppression such as gender, class, dis/ability, sexual orientation, religion, geographic location—as explored in the concept of intersectionality (Collins 2004) and the Wheel of Oppression (Samuels 2007).

REFLECTION

CULTURAL COMPETENCE

In order to achieve cultural competence it is important to consider:

- taking a firm grasp of what culture is and what it is not
- gaining insight into intracultural variation; do not assume each person from a certain culture will identify with what you understand that culture to be
- understanding how people acquire their culture, and culture's important role in personal identities, ways of life and mental and physical health of individuals and their communities
- being conscious of your own culturally shaped values, beliefs, perceptions and biases
- observing your reactions to people whose cultures differ from your own, and reflecting upon these responses
- seeking and participating in meaningful interactions with people of a variety of cultural backgrounds
- becoming aware of the cultural implications of personal space, body language, silence, eye contact and touch in your interactions with patients or clients
- examining policies and implementing practices in your care to tailor your interactions to meet patients' social, cultural, religious and linguistic needs.

WORKING WITH INTERPRETERS

Most students will require the services of an interpreter over the course of their placement or professional career. Interpreters are a service that is provided free of charge by healthcare institutions, and all interpreters will be fully qualified to work in the languages or dialects they specialise in. It is preferable to use the services of an interpreter rather than family members, as the information being translated may be subject to censoring or inaccurate translation when not undertaken by a trained translator. It is also important to consider the setting where the translation is occurring, especially if sensitive information will be discussed.

Points to remember when working with an interpreter:

- Planning is needed, as interpreters need to be booked in advance.
- Think about where and when you are going to hold the session.
- It takes double the length of time compared to a normal session and is tiring for all involved. You will normally only cover half the aimed-for content.
- There is no need to shout.
- Talk to the patient or client, not the interpreter.
- Maintain eye contact and positive body language with the patient or client, not the interpreter.
- Use short sentences and questions.

SUMMARY

All new environments require personal adjustment, especially the Australian healthcare system. Allow adequate time and space to orientate yourself to the workplace where you are going to be undertaking your fieldwork placement. Key points for consideration are: learn how the workplace interacts with clients, how the workplace links with other services or healthcare settings, what makes members of the interdisciplinary team work together in that workplace, and what is expected of you within that interdisciplinary team and the placement. Australia, along with many other countries, has a culturally diverse population. This means that you need to become culturally aware and competent in working with people from diverse backgrounds. This involves examining your own cultural background, opening yourself to the influence that culture has on a person's environment, and using this knowledge to improve the level of communication between clients, yourself and healthcare professionals. Develop the skill of using an interpreter.

Discussion questions

1 Think about the fieldwork placement you will be entering. How does it fit into the larger picture of the Australian healthcare sector? What services and healthcare professionals are linked to your placement setting? How do patients or clients access your placement setting? Is it a private or public service?

2 With the help of one of your peers, chat about their feelings about going on placement and what they have done to prepare themselves for this new experience. Was their preparation similar to yours? What was different, and how do you think their experiences could help you?

3 Identify five characteristics that are visible aspects of your cultural identity. Do these aspects accurately define what you would classify as who you are and where you come from? Which aspects are not easily apparent, and are these important to you? Ask your peer the same questions, and examine the cultural differences that may exist. In the light of any differences, how could you best work with them in a healthcare setting, with one of you as a health professional and the other as a client or patient?

Portfolio development exercise: Being culturally competent

Reflect on one to two critical incidents where you have seen or been involved in different cultural groups interacting successfully or unsuccessfully within a healthcare setting. Try to tease out any areas where a culturally aware or competent approach would be beneficial in improving the interaction from the perspective of the healthcare provider. Try to identify what competencies, skills would be drawn upon to facilitate an improved outcome.

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USEFUL WEBSITES

Australian Department of Health and Ageing: www.health.gov.au

Self-directed learning modules on cultural awareness and cultural competency for health professionals: www.nccccurricula.info/modules.html

CHAPTER 15

Working with Mothers and Babies

Joanne Gray

LEARNING OUTCOMES

After reading this chapter you should be able to:

- describe the key constructs of working with mothers and babies
- reflect on the nature of woman-centred care
- appreciate the importance of continuity of care for women
- commence your fieldwork placement with an understanding of the primacy of the woman and the family unit in working with mothers and babies
- identify the importance of the family unit as the foundation of support for mothers and babies
- recognise that pregnancy and childbirth are normal physiological processes
- understand the structures of a maternity unit.

KEY TERMS

Child and family health nurse
Confidentiality
Continuity of care
Family-centred care
Midwifery
Neonatal intensive care unit (NICU)
Woman-centred care

INTRODUCTION

On hearing that you will be working in a fieldwork placement with mothers and babies, many will tell you how wonderful this experience will be and how much you will enjoy it. This is very true, and being prepared for this placement by understanding the philosophy that guides the practice in these areas will ensure that you do indeed enjoy your experience.

This chapter will introduce key philosophical underpinnings in these areas of health practice. You will find that these differ from other areas you may work in. Working with

mothers and babies requires a set of skills that are different from working with other client groups.

This chapter is divided into the different areas of practice that you may encounter when working with mothers and babies. Care of pregnant women can take place in a range of settings. Your placement will, most probably, be with pregnant women in the hospital or community setting. Following the birth of the baby, you may be required to work with mothers during this early postnatal period. Again this may occur in the hospital or community setting, or perhaps in the woman's home. If you are working with babies who are unwell, your placement will occur in the special care baby unit, or neonatal intensive care unit in a hospital. Once mothers and babies are at home together, your placement is likely to be in a community setting.

There is something quite special about being given the opportunity to work with mothers and babies in your fieldwork placement. These experiences will enable you to put the theory that you have learnt into practice and to understand the realities of the profession you have chosen. Your fieldwork placement is a unique opportunity to communicate with women, learn about their experiences as a mother and gain an insight into parenting.

Good communication is a key competency in this placement. You will also discover what it is that you do not know, or are not sure about during this placement. Pursue this knowledge, then take this new understanding with you to your next placement, ensuring that your practice is informed by theory, and that theory informs your practice.

REFLECTION

Reflect on the following, then identify:

- What are the main considerations when you are working with mothers and babies?
- What do you think the role of the mother involves? List some key activities that you believe are part of the mothering role.
- Think about what a family means to you. Families come in a variety of forms, so it is interesting to reflect on what you believe a family to be. Jot down the different family structures that you know of.

AUSTRALIA'S MOTHERS AND BABIES

The National Perinatal Statistics Unit of the Australian Institute of Health and Welfare publishes data related to mothers and babies. Its most recent report (Laws et al. 2010) indicates that in 2008, 292,156 women gave birth to 296,925 babies in Australia. This was an increase of 0.9 per cent from the previous year. The mean age of these women was 30.0 years, with Aboriginal or Torres Strait Islander women accounting for 3.8 per cent of all mothers. Non-instrumental vaginal birth occurred in 57.5 per cent of births, with 31.1 per cent of women having a caesarean section. The caesarean section rate is compared to that of 1996, when it was 19.5 per cent.

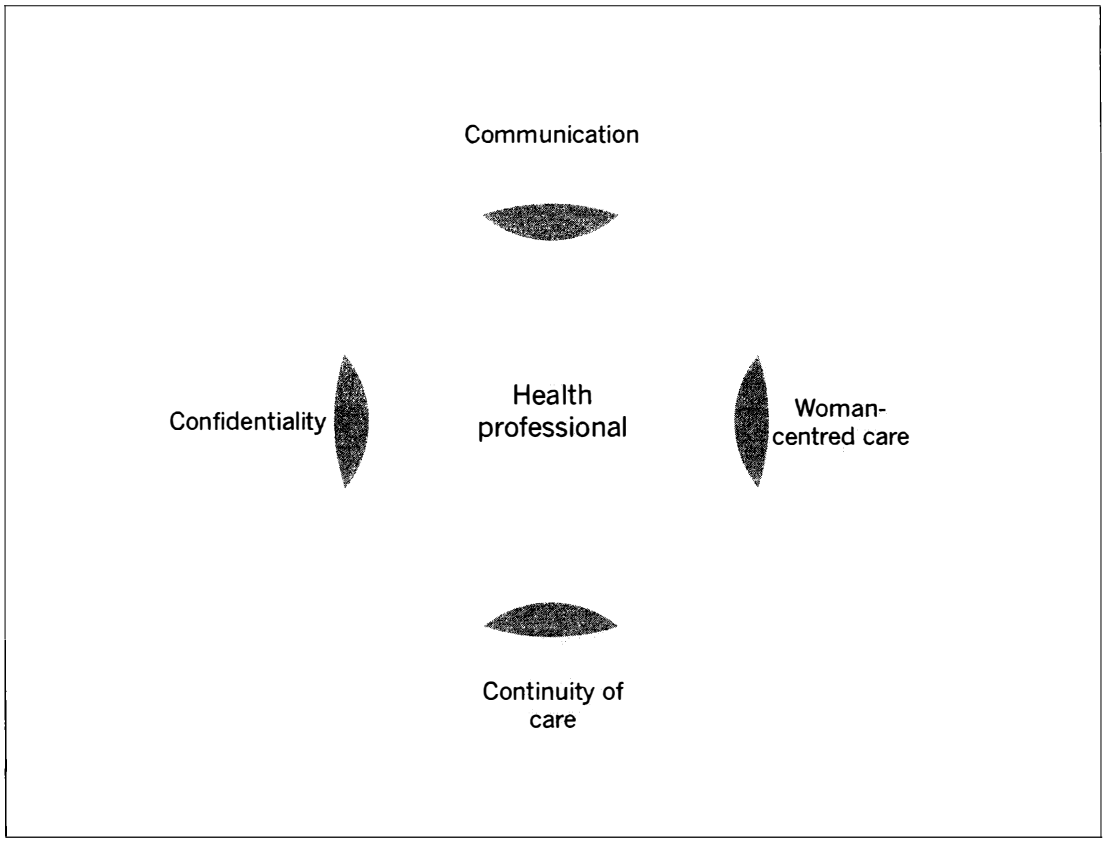
These statistics on women and babies tell us quite a lot about the maternity health setting. You will be working with young, well women, who mostly experience a normal life event of giving birth. You will also find that there is an increasing incidence of caesarean birth, which has an impact on the care required for women and babies. If you work with Aboriginal and Torres Strait Islander women, you will find that the maternal and infant mortality rate is much higher than that for non-Indigenous Australian women, and these women will often have other health problems that lead to complications in pregnancy.

Australia has a strong reputation for providing safe care to mothers and babies. Australian women experience low mortality and morbidity for maternity care, though this is not shared by women in rural communities, or by Indigenous women. It would be valuable to obtain a copy of the Report of the Maternity Services Review (Department of Health and Ageing 2009), as this provides a comprehensive overview of the Australian maternity system and its current challenges.

KEY SKILLS OF THE HEALTH PROFESSIONAL WORKING WITH MOTHERS AND BABIES

Figure 15.1 depicts key skills that are essential when working with mothers and babies.

Figure 15.1: Main skills of a health professional working with mothers and babies



WOMAN-CENTRED CARE

Woman-centred care is a key philosophical approach underpinning working with mothers and babies. This approach recognises the primacy of the woman and the woman as the centre of care provision. It has been defined as follows:

> Woman-centred care is a concept. It implies that **midwifery**:
>
> › Focuses on the woman's individual needs, aspirations and expectations, rather than the needs of the institution or professionals;
> › Recognises the need for women to have choice, control and continuity from a known caregiver or caregivers;
> › Encompasses the needs of the baby, the woman's family and other people important to the woman, as defined and negotiated by the woman herself;
> › Follows the woman across the interface of community and acute settings;
> › Addresses social, emotional, physical, psychological, spiritual and cultural needs and expectations;
> › Recognizes the woman's expertise in decision making. (Leap 2009: 12)

Recognising woman-centred care as a key construct in working with mothers and babies will enable you to understand the differences inherent in this fieldwork placement. The identification of the woman, and those who are important to her as her family unit, is fundamental to providing care. Women are mostly self-determining in the care of themselves and their baby, and their choices should be respected.

CONTINUITY OF CARE

CASE STUDY

Fragmented care

Donna is a 36-year-old woman and she is expecting her first child. Donna visits her local GP (1) to have her pregnancy diagnosed. Donna is then sent to the local pathology service (2) for her routine pregnancy blood tests. Donna, accompanied by her partner Michael, also has an ultrasound scan (3) to determine her estimated date of birth. Donna and Michael have decided to access the local maternity unit in a public hospital. Donna organises an appointment for the booking-in visit (4). At this visit, Donna provides a comprehensive personal history, and she is given a number of resources for reading during her pregnancy. Donna makes her first appointment at the antenatal clinic, and she is seen by a midwife (5). As Donna has some concerns about her age and the possible effects on her baby, she is seen by the obstetric registrar (6). Donna decides to have further antenatal screening (7). Donna and Michael are relieved to learn that the screening test indicates that all is well and Donna's pregnancy continues without complication. She has a further eight visits at the antenatal clinic, and sees a different midwife every time (15). Donna commences labour at home just after her due date and

presents to the birthing unit (16) to find she is established in labour. She labours well, and her period of time in the birthing unit goes over a change of shift so she is cared for by another two midwives (18). After birth Donna requires some intravenous fluids and the cannula for venous access is inserted by the resident (19). Donna is reviewed by the obstetric registrar (20), and she is then transferred to the postnatal unit.

As you can see from this case study, Donna, who is a well woman, experiencing a healthy, uncomplicated pregnancy, was seen by at least 20 health professionals. This case study did not calculate the students she is likely to have met, or the care that she received in the postnatal unit.

QUESTIONS

1 What do you see as possible concerns related to this fragmentation of care?

2 Reflect on how Donna may feel about having to share her story, and the personal journey of her pregnancy, with so many different health professionals.

As the case study above has shown, women may experience a very fragmented approach to their care during pregnancy and birth. **Continuity of care**, which is known to confer benefits when working with mothers and babies, is broadly defined as: 'For continuity to exist, care must be experienced as connected and coherent. For patients and their families, the experience of continuity is the perception that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future' (Haggerty et al. 2003: 1221). In maternity care, evidence tells us that women have better outcomes when they experience continuity of care with a midwife (Hatem et al. 2008).

What does this mean for you working with mothers and babies? Having an appreciation of the value of continuity of care will assist you when you establish a relationship with women. Simply by acknowledging to the woman that 'you have probably already told someone your history before' indicates to the woman that you are aware of what she may have experienced. You can also try to have continuity for yourself by, wherever possible, trying to provide care to the same women and babies you have previously met.

SUPERVISOR PROFILE

ALLISON CUMMINS

Allison has been working as a midwife for over twenty years, mostly in the hospital or birth centre setting and occasionally in a woman's home. With the notation of eligibility to her registration as a midwife in Australia, Allison can now provide women with care throughout their childbearing experience in the woman's choice of home or hospital. Allison is passionate about midwifery and has expanded her career to teaching midwifery students at the University of Technology, Sydney.

(continued)

1 *Tell us about your role. What does a typical day involve?*
Providing continuity of care to women throughout their pregnancy, birth and the early parenting period is highly satisfying to both the woman and the midwife. I have the opportunity to build a relationship with a woman and her family surrounding one of the most life-changing events she will experience. Pregnancy and birth are times of joy and celebration, but while the transition to parenthood is joyous it can be overwhelming and at times exhausting. Women and their families need to have a trusted midwife who not only supports them during these experiences but educates and enables them through the transition from the beginning of pregnancy to the demands of a new baby. Providing continuity of care to women and their families provides the opportunity to work with women in this transition to parenthood from early in the pregnancy.

This woman-centred philosophy is the main focus of my teaching. All the midwifery skills and competencies taught in the midwifery programs are based on working in partnership with women and allowing the woman to make decisions based on information sharing rather than 'expert opinion'.

2 *What are some of the challenges you face as a midwife and midwifery educator?*
The biggest challenge I have experienced in my career is working within a resource-depleted maternity service, namely working in publicly funded hospital settings. The midwifery care provided in these settings is excellent. However, it is often fragmented; that is, the woman meets several midwives and often obstetricians in her childbearing journey. In Australia, the overwhelming majority of women will discover they are pregnant, visit their general practitioner who confirms something the woman already knew and then refers her to an obstetrician at a public hospital. The woman may never meet this obstetrician, instead she will meet maybe one or more midwives during her pregnancy or a variety of doctors in training to be obstetricians. The woman will present to a medicalised labour ward/delivery suite and have an unknown midwife provide care throughout her labour and birth experience. Often this is a time that the woman feels quite vulnerable and it is an extremely intimate experience. Having a known midwife is very important for the woman at the time of labour and birth.

The other huge challenge is teaching woman-centred care to midwifery students and having them return after clinical placement to state this is not what they see out in the real clinical setting. The disparities are a source of frustration for the students and often their idealised view of midwifery is shattered.

It is important to acknowledge that occasionally women will experience foetal or neonatal loss and this is a devastatingly sad experience. One small consolation is the woman and the family always appreciate having the support of a known midwife or the student midwife.

3 *What is unique about providing continuity of care to a woman in terms of student learning?*
The midwifery students are required to provide continuity of care to twenty women within their course. This opportunity allows them to practise woman-centred midwifery care within the confines of the resource-restricted public health system.

This continuity of care experience is cherished by the midwifery students and they acknowledge they learn so much from working in this way with the woman and her family. The midwifery students learn about all aspects of midwifery care provision from the aspect of a woman. In this sense they are learning 'in context' across the continuum of pregnancy, birth and the early parenting period. The students witness the progress of a pregnancy and the feelings a woman experiences at different gestations. The student then is privy to each family's unique adaptation to their new baby.

4 *What skills are important for working in continuity of midwifery care?*
The most important skills for working with women in continuity of care are often difficult to teach. Rather the student needs a role model or mentor to assist them to develop communication skills. Communication in this setting surrounds the woman's choice and at times her choice may not be the same choice the midwife or student would make, and this is a huge challenge for students to understand. The student has to adopt a non-judgmental way of working with women and offering achievable options that the woman can decide on. Other skills are taught in the classroom and practised on the woman, such as abdominal palpation, and measuring vital signs such as blood pressures and temperatures. Women as a rule are happy to work with midwifery students as they offer continuity in an often fragmented maternity service.

5 *What are some useful resources for students to review prior to starting the placement?*
The midwifery students are exposed to midwifery continuity of care through a number of subjects; it is a central theme running through the university programs and the National Standards for midwifery competency. The students should be well aware of the concept of continuity of midwifery care prior to their first clinical placement when they will meet women whom they will 'follow through' their pregnancy and birth experiences. The students are requested to read many texts, journal articles that define and provide evidence for the benefits of continuity of midwifery care.

6 *What would you expect from a student on placement?*
First year student: Students are encouraged to be active participants from their first clinical practice placement. The students are thoroughly prepared for practice in the classroom and simulation laboratories prior to going out to clinical practice. It is frustrating for students to be asked to observe practice, they wish to begin practising and start to develop midwifery skills that are used in midwifery continuity of care.

Second year student: These students have already begun to develop relationships with women for their continuity of care requirements and several have attended births for these women. The students are continuing to develop and practise these skills, particularly with women that develop complexity in pregnancy and birth. The students will have more contact with professional colleagues such as obstetricians and other medical providers to work together with women even when their pregnancy develops a complication.

(continued)

Third year student: These students are beginning to consolidate all the skills and knowledge they have gained over the course. These students are preparing to work as registered midwives and sometimes feel daunted at the prospect of being able to register and provide continuity of care to women and their families without the direct supervision of another midwife. The students are finishing their continuity of care experiences and terminating professional relationships with women and their families that can sometimes make them sad but prepares them for working as a midwife.

REFLECTION

COMMUNICATION: THE LANGUAGE OF MATERNITY CARE

The words we use when communicating with women are important. For example, what message do you think the following words and phrases send to women:

- failure to progress
- incompetent cervix
- delivery (as opposed to birth)?

It is important to be careful with our language when communicating with women, and to convey positive messages to show that we are not condescending or dismissive. Calling every woman 'dear' or referring to them as 'ladies' can sound condescending and inappropriate, and not woman-centred.

When you enter your fieldwork placement, think about the language that you use, and the language you hear around you.

1. What messages are conveyed about women in the handover reports?
2. Do health professionals make judgments about women simply by the language they use?

CONFIDENTIALITY

The concept of **confidentiality**, which includes elements of privacy, is an ethical responsibility for health professionals. Patients will often share very personal details with their health care professional, so it is essential that we respect their right to confidentiality and show competence in our professional attitude and behaviour.

Having a baby is a very exciting, but also a very private time in a woman's life. The family often wish to be the ones who share the news of the arrival of a new baby. As health professionals, we need to respect this, and ensure we do not accidentally inform family members or friends. Family dynamics can be complex: the choices that women make around who is told about the birth of their baby, and when, can be difficult decisions.

When you work in smaller communities, for example in a rural area, members of the community are often well known to each other. Therefore it is important that you are culturally competent and are very careful about the information you share with others and what you discuss in public areas. It might be that, when you are sharing a story from your workday with a colleague, you mention that you were working with a woman who had twins that day. Although you have not mentioned the woman, or the hospital, or anyone by name, it is likely that only one woman in that community had twins that day, so that woman and her family are automatically identified.

Women also share very confidential information with their midwife or obstetrician, and this may be recorded on her health record. A woman, for example, may identify her previous pregnancy history, including any terminations of pregnancy. Some women choose not to share this information with their partner. It is important, therefore, that you respect the woman's wishes to keep this information confidential. In other circumstances pregnancy screening may have identified the gender of the baby. Some parents choose not to be told this. Again, it is essential that you respect this and do not accidentally disclose confidential information.

THINK AND LINK

Chapter 12 discusses ethical issues in more depth, and legal issues including confidentiality are discussed in the Appendix. These readings link to the concept of confidentiality, including privacy and ethical responsibility when working with mothers and babies.

WHO'S WHO: THE MATERNITY CARE WORKFORCE

Every fieldwork placement that you attend will have different staff. It is helpful for you to understand who they are and what they are responsible for. Within a hospital maternity unit there will be unit managers (titled either midwife or, sometimes, nurse). The managers of each unit, or area, hold the overall responsibility for the day-to-day operation of the unit. Midwives are the most prevalent health workers in maternity services.

In Australia it was traditional that midwives were prepared for practice after first gaining a nursing qualification. However, in 2002 South Australia and Victoria commenced Bachelor of Midwifery programs, and most other states and territories have now followed. These programs (sometimes referred to as *direct-entry*) are becoming the preferred route to midwifery registration in Australia. This means you will be working alongside midwives who are not nurses. Midwives have a defined scope of practice, and are registered as a separate discipline to nursing. As a distinct discipline, they are able to provide care, independently, to women during their pregnancy, labour and birth, and into the early parenting period.

You will also work with medical residents, registrars who are in obstetrics training programs, and obstetricians. The maternity setting is multidisciplinary, depending on the needs of each woman, so you will also encounter anaesthetists, members of the endocrinology team or other medical or allied health specialists.

REFLECTION

LEARNING ANOTHER LANGUAGE

You may not be familiar with many words that are associated with maternity care (see Table 15.1). It would be helpful to find the meaning of some of the common words or phrases that you will find used every day in relation to mothers and babies, and reflect on their implications for clients.

Table 15.1: Learning another language

Word	Definition	Reflection
Antenatal period		
Postnatal period		
Parity		
Gravid		
Primipara		
Multipara		
First stage of labour		
Second stage of labour		
Third stage of labour		
Postpartum haemorrhage		
Forceps birth		
Vacuum birth		
Caesarean section		
Gestation		
Term		
Postdates		
Preterm		
Fundus		
Involution		
Puerperium		

Source: Terms sourced from Gray et al. 2009

The maternity unit

Most of the work that you do with women and babies will occur in the hospital maternity unit. These units differ from the typical hospital ward unit. Most women are well and are able to move freely around the unit without the need of assistance. Indeed, the maternity unit should be designed to enable women to provide their own care and also to provide care to their babies.

The unwell baby

Sick babies are cared for in the hospital in the **neonatal intensive care unit (NICU)**. The type of care provided to the unwell baby depends on the specifications of the NICU, with specialised units being able to care for extremely premature babies, and babies who require surgical intervention. All maternity units are able to provide care for well babies, and some can also then care for babies once they no longer require the specialised skills of a NICU.

Having a baby in the neonatal intensive care unit is a most distressing time for new parents. Some parents may have had some forewarning of the need for their baby to be admitted to a NICU. For other parents, the birth of an unwell baby is completely unanticipated. If women are aware that they will give birth to a baby who requires admission to a NICU, they will have probably been given a tour of the unit and have met the staff who work there. Staff in the NICU are very aware of the need to keep the family unit together during this difficult period. Cooper and colleagues (2007) suggest that **family-centred care** is about 'viewing the family as the child's primary source of strength and support'. They further suggest that 'this philosophy incorporates respect, information, choice, flexibility, empowerment, collaboration and support into all levels of service delivery' (Cooper et al. 2007: S32).

CHALLENGES WHEN WORKING WITH MOTHERS AND BABIES

Outcomes for mothers are not always positive. During your fieldwork placement you may work with women who experience the death of their baby through stillbirth or neonatal death. This is a devastating experience for the woman and her family. It is important that the woman is given access to support and perhaps counselling and you should also seek support to assist you through this difficult experience. You may find it helpful to read the articles in an issue of *Birth Matters* (Autumn 2009), which was devoted to perinatal loss.

MOTHERS AND BABIES IN THE COMMUNITY

The care of women and babies is passed from their midwives to the **child and family health nurse**. The timing of this transfer varies according to the care the woman has received, and where she has spent her postnatal period. The child and family health nurse, who works

in the community, will often also conduct home visits. The role of this health professional extends from the antenatal period, when the nurse often meets the woman and her family in their home, until the child is aged five years. This scope of practice enables the nurse to establish a relationship with the family so that care can be built on the family's strengths. It is recognised that developing a strong partnership provides the best means of supporting families.

THINK AND LINK

Chapter 16 discusses working with families and children. This chapter links with this chapter as Chapter 16 discusses the various issues that arise when children have developmental needs and they and their families need support within the community from a variety of health professionals.

SUMMARY

This chapter has provided you with some insights about this specialised area of practice to prepare you for your fieldwork placement working with mothers and babies. Remember to listen when you are on placement and reflect on all that you hear, see and experience about mothers and babies.

This chapter had identified the key aspects of working with mothers and babies as woman-centred care, continuity of care, confidentiality and communication. A snapshot of Australian mothers and babies has been provided to give you the broader context for your placement. The fieldwork placement areas, such as the maternity unit and the community, have been described, allowing you to gain a better understanding of who you will be working alongside.

Discussion questions

1 Do you believe that parenting is valued as an important role in society?

2 Grandparents are now often being asked to take a more active role in the care of their grandchildren as many new parents need to return to work for financial reasons. What do you think are the benefits and concerns of this increased expectation on grandparents to care for young children?

3 What have you found to be the most rewarding and the most challenging aspects of working with mothers and babies? Why was this?

4 How well do you believe that a woman's cultural understanding of birth and parenting is incorporated into the care you experienced while on placement? Did you gain an understanding of different cultural aspects of birthing and parenting?

Portfolio development exercise: State of the world's midwifery

In order to gain a wider understanding of midwifery, mothers and babies from an international perspective go to the following link: www.unfpa.org/sowmy/report/home.html.

Watch the video, read the report and view the links. From this report you will gain a much wider view of maternal and infant health.

As an exercise for your portfolio, write a reflection on just a few of the differences between what you understand about the health of women and babies in Australia and what you now know about mothers and babies from other countries.

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FURTHER READING

Birth Matters, Autumn 2009.

CHAPTER 16

Working with Children and Families

Kelly Powell

LEARNING OUTCOMES

After reading this chapter you should be able to:

- reflect on several types of paediatric settings
- articulate what makes an effective paediatric clinician
- know what to prepare for when working with children and families
- understand the role of the allied health student in paediatric fieldwork
- articulate how working with children and their families differs from working with an adult
- reflect on the clinical reasoning process.

KEY TERMS

Acute hospital setting
Autism spectrum disorder (ASD)
Clinical reasoning
Consulting therapist
Discipline-specific skills
Family-centred practice
Generic role
Inpatient
Outpatient
Paediatrics
Transdisciplinary team

INTRODUCTION

Health professionals who work in **paediatrics** consider the assessment and treatment of children who have a range of neurological, developmental, genetic and medical conditions that have an impact on their ability to participate in everyday situations. Paediatric settings present you, as a health professional student, with many challenges because the settings are varied—from acute hospital setting, community-based early intervention team or school-based setting to working in private practice. The clients and the role of the

health professional also vary greatly. This chapter outlines the main issues that you must consider when working with children and their families. Your role will vary depending on your year level at university and the setting in which the fieldwork placement is taking place. When working with children and their families, it is important for you to have an understanding in three main areas: family-centred practice (as this model is used in many settings); typical development of children; and models and frames of reference used to guide intervention. The following case study raises important issues that are addressed throughout this chapter.

CASE STUDY

Sarah

Sarah was a child aged 4 years 6 months who had been given a diagnosis of **autism spectrum disorder (ASD)**. Her parents were extremely distressed about this diagnosis but were keen to assist their daughter to achieve her full potential. Sarah was seen by a multidisciplinary team at a local early intervention agency.

The team assessed Sarah at the clinic as well as attending a session at her local kindergarten. Sarah was found to be non-verbal, constantly mouthing objects, flapping her hands, walking with a wide-based gait and constantly falling over. She required assistance with all self-care activities and was a fussy eater.

Following assessment and several intervention sessions, the team was very concerned that Sarah's mother was not following through on the recommended intervention strategies. Sarah's mother had spoken to her family service coordinator (the early intervention team leader) and expressed concerns that the team's recommendations were 'babyish and pitched at too low a level for Sarah'. The family then withdrew from the early intervention agency and sought services elsewhere. Twelve months later, the family returned to the early intervention agencies requesting ongoing services because of a lack of suitable services in the area. The parents were open to discussion with the staff about the needs of their daughter.

This case study raises a range of important issues that you may encounter when you undertake a fieldwork placement working with children and their families. Competencies relating to communication (the ability to listen to the family's concerns and to articulate these in a professional manner) and knowledge (particularly in relation to the principles of family centred practice) are fundamental in these situations.

QUESTIONS

1 What do you think is happening in this case study? Why did the family withdraw?

2 Could the team have done anything differently to engage with this family?

TYPES OF FIELDWORK SETTINGS

The type of setting and the clinician's role within each setting will vary. As a result, your role as a student will also vary. The most common types of settings in which you may be

required to undertake fieldwork include acute settings, community settings, school-based settings and private practice.

Acute settings

Children can be seen within an **acute hospital setting**, either as an inpatient or on an outpatient basis. An **inpatient** is a child who is staying in hospital and an **outpatient** is a child who lives at home but comes into the hospital for an assessment and/or treatment. Sessions can take place both on the ward and in the hospital departments. Parents may or may not be present during the individual sessions. This is an important issue that needs to be discussed with families prior to the individual sessions (due to competencies of professional behaviour and knowledge of family-centred practice). Because assessment, intervention strategies and report-writing guidelines vary from setting to setting, it is important to talk to your fieldwork educator in relation to:

- assessment tools commonly used
- types of reporting required (progress notes, discharge summary)
- specific short-term intervention strategies.

The work undertaken by you as a student will vary considerably depending on your year level. A first or second year student may have an observation role and be assigned generic tasks (such as filing, developing information sheets), whereas third and fourth year students will have more of a hands-on role with possibly the opportunity to administer assessment and treatment techniques under supervision.

Community settings

Paediatric services in community-based settings are often limited to children aged 0–6 years because of funding arrangements. Waiting lists are often a major concern within these settings. At times, a child may receive a diagnosis, but then remain on a waiting list for a long period before intervention commences. It is important to consider the implications for the child and the family in this situation. Knowledge of the length of waiting times is an important fact that you need to know before seeing the family.

Many community-based settings require health professionals to take on a **generic role**. A **generic role** often means that a health professional may have to take on the role of **family services coordinator**, the primary person responsible for the organisation of additional services such as seeking funding and organising respite and family meetings. Discipline-specific intervention—assessing and treating in the profession you were trained in—may also occur in multidisciplinary teams, or you may find yourself working in a **transdisciplinary team**, where you carry out treatment suggested by another health professional as well as your fieldwork educator. Many paediatric settings have a number of disciplines working together with family and child in multidisciplinary teams. In these teams, roles can be clearly defined (for example, at some community-based services physiotherapists undertake wheelchair prescriptions whereas occupational therapists do this in hospital settings), or roles can be generic. For example, an early intervention worker is allocated to provide the service to the child and family. It is important to be aware of the role of other team members, so that you know who to refer to in relation to specific issues that may arise. Consult your fieldwork

educator if you are unsure about the boundaries of your role or how your role fits into the rest of the team (competencies here are a combination of discipline-specific knowledge, skills and behaviours that are important for functioning successfully in this context).

Consideration must be given to the environment in which you will be seeing the child: is it in the clinic, the home, day care or kindergarten? Be mindful that the behaviour you see in one setting may be completely different to another. For example, a young child in a child care setting may present with increased behaviour levels of activity, inattention and distractibility because of the amount of noise and stimulation in this setting, but may present as placid in the home environment.

SUPERVISOR PROFILE

TARA ROBERTS

Tara is an occupational therapist who has specialised in working with children for twenty years. She enjoys helping children and their parents/carers reach their chosen goals in occupations that enable the child to do what they have to do, want to do and need to do in life. Tara also works part-time as a lecturer and clinical fieldwork supervisor in Deakin University's Occupational Therapy and Science degree course.

1 *Tell us about your role. What does a typical day involve?*
I am an occupational therapist working in a non-government agency on the Early Childhood Intervention Team in a large regional town. I work in the Autism Early Learning Program (AELP) with other professionals including speech pathologists, psychologists, early childhood educators and additional assistants.

This program runs three times per week in a local preschool with our clients being twelve children with autism spectrum disorder (ASD). The clients are 4–6-year-olds who have significant developmental disabilities and complex and challenging behaviours. The children attend for two-hour sessions. My role is to assess, plan, implement and evaluate the OT needs for the individual children within this group program.

A large part of my day also involves my role as the key worker/family service coordinator for four of the families attending the program. This may involve tasks such as facilitating individual education plan meetings, conducting home visits, case meetings with paediatricians, applying for equipment funding or supporting parents in accessing resources to support their child's therapeutic goals.

2 *What are some of the challenges you face as a clinical supervisor?*
Balancing my clinical role with the family service coordinator/key worker role. Initially students often don't see the importance of the latter until they have been with us for a period of time.

3 *What is unique about this setting in terms of student supervision?*
Students will have a placement that will be fun, 'hands on', challenging and never dull! Having opportunities to work closely with parents, siblings and significant others of the clients, e.g. child care staff, grandparents, and experiencing firsthand how individuals with ASD present with unique strengths and weaknesses.

4 *What clinical skills are important for this setting?*
Knowledge of typical child development; knowledge of ASD; willingness to collaborate with other professionals; lots of initiative, adaptability and a sense of playfulness; and confidentiality, mature communication skills and good organisation skills.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*
First year: Prepare professional practice skills. Read Chapter 1, Chapter 15 and this chapter. Review child development literature.
Second year: As above (1st year) and review behaviour modification literature.
Third year: As above (2nd year) and become familiar with the Autism Spectrum Disorder diagnostic criteria (DSM IV). A useful text is: Brereton, A. & Tonge, B. (2005). *Preschoolers with Autism: An Education and Skills Training Programme for Parents. Manual for Parents*. Jessica Kingsley Publishers, London.
Fourth year: As above (3rd year) with additional research into evidence-based practice with autism spectrum disorder, e.g. The Alert Program: How Does Your Engine Run, DIR Floortime approach. Useful online resources include:
Autism Help: www.autismhelp.com.au
Autism Victoria: www.amaze.org.au
Monash University Medicine, Nursing and Health Sciences: www.med.monash.edu.au/spppm/research/devpsych/actnow/project.html

6 *What are some of the key learning opportunities available to students?*
Learning opportunities include:
- seeing best practice principles of early childhood intervention 'at work' in a local community setting
- lots of 'hands-on' opportunities to work directly with children with ASD
- assessment and information gathering: use of observational checklists for independence/self-care skills, formal motor and sensory processing assessments
- applied evidenced-based intervention strategies.

7 *What would you expect from a 1st year, 2nd year, 3rd year or 4th year student on placement?*
First year: Professional practice skills such as confidentiality, communication skills, and awareness and adherence to Occupational Health and Safety policy. Engaged observation of clients and an awareness of their discipline-specific role with the client population.
Second year: As above, and an expectation to describe and discuss their observations of the clients in relation to assessment, documentation, goals and intervention.
Third year: As above and beginning to use clinical reasoning in an active role with the clients. Basic competency is using assessment tools, forming goals and collaboratively formulating and implementing treatment goals. Being more active as a member of the team for the duration of the placement and showing initiative and willingness to take on appropriate tasks independently.
Fourth year: As above with a focus on developing independence and consolidating skills.

8 *What parts of the placement could students find challenging? What tips do you have for them?*

Complex and challenging behaviours are occasionally displayed by clients/children with ASD. These may include biting, hitting, extreme anxiety and/or agitation, withdrawal and a variety of unusual reactions to the sensory demands of the environment.

These behaviours can be confronting for some students. OH&S is a top priority for all staff, students and clients and can be managed in a variety of ways. Being aware of and adhering to any risk assessment plans your supervisor advises you are essential.

School-based settings

A variety of school settings either employ health professionals directly or contract services for consulting health professionals. For example, allied health professionals are often employed in a special school setting, while nurses can be employed by the government and work in a school district.

Consulting health professionals are very often therapists. The **consulting therapist** is given very limited time to assess and establish recommendations for the child in school settings (often therapists will see children once a month or even once a term). The amount of intervention usually depends on the funding provided for the health service. It is extremely important in these settings to talk with the main caregivers (especially the teacher, integration aide or parent) about their concerns about the needs of the child. A consulting therapist is not necessarily the 'expert' but needs to see himself or herself as part of the school team where common goals can be met (competencies of professional behaviour, communication with others and ethical behaviour need to be understood here). These goals are often outlined in parent support group (PSG) meetings, and if the health professional cannot attend (which is often the case because of funding constraints), it is important that he or she gains access to these goals (and where possible contributes to goal-setting before the meeting).

Private practice

There are a variety of reasons why a family might seek private services. Often waiting lists for public services are too long, and some parents choose to find a clinician who specialises in a specific field. A student's role within the private practice setting is often limited to observation or conducting assessments under close supervision from the clinician. It is important to be aware that, because of the fee-for-service consideration, many parents prefer the qualified clinician to conduct the sessions but are happy for the student to observe. This opportunity to observe the clinician working directly with the child is an extremely valuable one that may not be always available to you when you graduate. Make sure you take notes about activity ideas and strategies used throughout the session, but remember to maintain confidentiality, which is a vital competency that reflects both professional and ethical behaviour.

THINK AND LINK

If you find yourself undertaking a placement in a private practice, you may find that you are observing your fieldwork educator interacting with clients more than in other settings. Chapter 21 provides information about working in private practice in more detail, and discusses issues that you need to be aware of if undertaking a fieldwork placement with a private practitioner.

WORKING EFFECTIVELY WITH CHILDREN AND FAMILIES

In order to have a successful fieldwork experience, it is necessary to understand what makes an effective paediatric practitioner. Dunst and Trivette (1996) discussed the elements of effective intervention as:

- technical knowledge and skills
- help-giver behaviours and attributions
- participatory involvement.

Figure 16.1 incorporates these aspects, clearly demonstrating what is required in order to become a competent paediatric practitioner.

Often only after years of experience can a clinician become effective in all four areas: generic skills, *discipline-specific skills*, interpersonal skills and **family-centred practice**. However, you can begin to develop these skills during fieldwork placement (competencies of skill development and knowledge of disability and conditions are fundamental for all paediatric settings).

PREPARATION FOR WORKING WITH CHILDREN AND FAMILIES IN A FIELDWORK SETTING

Before you begin the fieldwork, or very early in the fieldwork placement, it is important that you review the following:

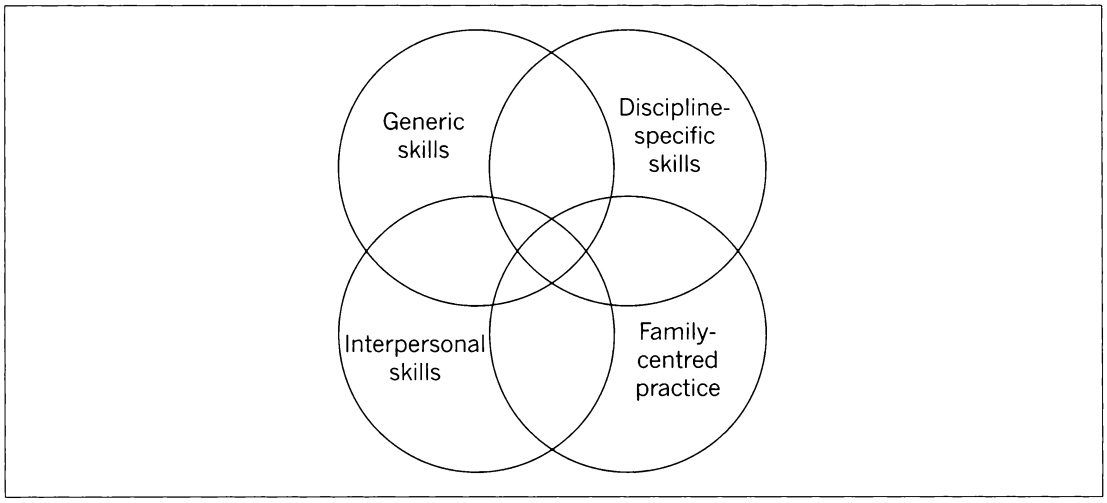
- knowledge of typical development
- common assessments and screening tools
- underlying models and frames of references
- knowledge of childhood disabilities and conditions
- knowledge of commonly used intervention strategies.

Review of these areas will help you to begin filling the circles of generic and discipline-specific skills (see Figure 16.1).

Knowledge of typical development

It is important to understand at what age typically developing children acquire various skills. Keep in mind that all children vary in their milestones (for example, it is not unusual

Figure 16.1: The effective paediatric practitioner



that a typically developing infant can learn to walk anywhere from 9 months to 18 months of age). You do not necessarily have to memorise all the milestones, as there are many checklists available. Ask your fieldwork educator which are relevant to your profession.

Knowledge of common assessments and screening tools

Assessments and screening tools will vary depending on the facility in which you will be working. If you are required to undertake an assessment with a child, it is a good idea to practise the assessment several times on your partner, parent or another child. If the opportunity presents itself, first observe a qualified professional undertaking the assessment. Where possible (and provided you have parental consent), videotape an assessment session to enable you to review not only the child's skills but also your own. This can be a valuable way to reveal how you interact with the child, the language you use and the structure of the session.

Knowledge of the underlying models and frames of reference

It is important that you understand why you are undertaking a particular task, activity, strategy or technique with a child. Although some models and frames of reference can be applied to all ages, others are specific to working with children. Common ones used by health professionals in paediatrics include developmental, biomechanical, behavioural, psychosocial, neurodevelopment and cognitive frames of reference (Kramer & Hinojosa 1999).

Knowledge of developmental disabilities and childhood illnesses

Before commencing the fieldwork placement (or very early on), it would be useful for you to find out the main diagnoses, disabilities or conditions of children that you may see in the facility you will be going to. For example, some organisations see only children with a specific condition (such as children with physical disabilities). Other organisations see any child who is referred (for example, a community health centre accepts referrals for children with a wide range of developmental, neurological, genetic and learning difficulties). Before

you assess or treat a child, it is helpful to read about the child's condition or diagnosis so that you will have some knowledge before you actually see the child.

Knowledge of common intervention strategies

It is not possible (or practical) here to discuss a range of intervention strategies, as you can only gain such knowledge while on placement. Before going on placement, ask your fieldwork educator what types of intervention strategies are used in the organisation. Prior reading about common strategies related to your profession is recommended.

Knowledge in the above areas leads to improving your skills and preparing you for fieldwork.

YOUR ROLE IN A FIELDWORK SETTING WORKING WITH CHILDREN AND FAMILIES

The role of the clinician, and hence the role of the health student, will vary from setting to setting. At times the health professional's role changes, depending on client needs. For example, a physiotherapist may be supporting a child who has cerebral palsy at school on a monthly basis through consultation with the teacher and integration aide, but after that child has tendon release surgery, the physiotherapist may see him weekly for a period of time.

At times, a child may be referred for assessment only. Formal and standardised assessments are often used in these situations (basic knowledge of these assessments is important for you to know). At other times, a health professional may need to see a child in his or her natural environment and undertake an assessment of skills through observation of specific tasks. It is important never to undervalue the observation process as an ongoing assessment. Intervention also varies, and can often be provided through consultation with the caregiver without directly working with the child. For example, it may be important to explain strategies to parents, teachers or integration aides so intervention techniques, such as the Hannen program or sensory processing, can be carried out at home or school by the adult working with the child. Intervention can also take place on a one-on-one basis or within a group setting.

Again, your specific role will depend on the setting and the level of your experience: the year you are in at university and whether you have prior experience in paediatrics. If you are asked to observe the session, use this time to look at a range of important issues. These observations will help you to fill the interpersonal circle outlined in Figure 16.1. Make observations of:

- how the health professional engages with the family or caregiver (through listening, watching and feedback)
- how the health professional engages with the child (language used, behaviour management and physical positioning of the child)
- specific activities and strategies that are used when engaging the child
- what can the child achieve
- the tasks or activities that are difficult for the child.

You may have the opportunity to provide direct assessment or intervention of a child under supervision. It is important not to feel threatened by this experience but to approach it as a valuable learning opportunity. Ask for feedback from your fieldwork educator so that you may know how well you have done or where you can improve. Even experienced health professionals can learn from others! Effective communication with your team members and supervisors is just as important as your ability to communicate effectively with clients or patients.

It is extremely important to consider the environment in which you will be working with the child. This will often be dictated to you by your fieldwork educator, the setting and the time available. Understand that a child can perform differently in different environments. Gathering as much information as possible about the child's performance in each setting is important to your assessment and intervention strategies. For example, if the child is easily distracted in the group setting, but is very placid at home in a quiet setting, you may make recommendations about where he or she could work best on more complex tasks.

HOW IS WORKING WITH CHILDREN AND FAMILIES DIFFERENT FROM WORKING WITH ADULTS?

The case study earlier in the chapter outlines the importance of knowing and understanding the principles of family-centred practice. You may be working with the child, but the family is also your client. Rosenbaum (cited in Rodger & Ziviani 2006) describes three main assumptions of family-centred practice:

1. Parents and family members are the most consistent people in children's lives and the most knowledgeable about their own children
2. Families are different and unique
3. Optimal child functioning occurs within a supportive family and community context. (2006: 30)

The four key interpersonal skills outlined by McBride (1999) are important to develop when working with children and their families regardless of the type of service:

- be positive
- promote family choices and decision-making
- affirm and build on the positive aspects and strengths of the child and family
- honour and respect the diversity and uniqueness of families.

It is important that you ask members of the family about their concerns and the specific areas they would like you to address. All families are different and unique, and therefore their concerns, knowledge and needs will differ. An experienced health professional said, 'You can only go as fast as the parents allow'. Some families will crave information, knowledge and strategies, and some will only want to hear a small amount of information at a time. How do members of the family like to receive information: through verbal discussion, handouts or books or through practical demonstration? Remember that the internet has opened up opportunities for families to speak to other families all around the world (Stagnitti 2005). Many families come to sessions extremely knowledgeable about their child's condition and

possible intervention techniques. However, information found on the internet is often not screened and could be incorrect or not relevant to their child.

In all settings, it is important to realise that members of the family (in particular the parents) are the experts when it comes to their own child. (If there is a child protection issue, you need to discuss this with your fieldwork educator immediately since this is an ethical responsibility you have) In the Case Study: Sarah, the health professional's opinion about Sarah's skills was very different from that of the family. The health professional needed to discuss her findings with the members of the family and listen to their concerns and needs, finding out where they were in relation to their understanding of Sarah's skills. In the case study, intervention strategies recommended by the health professional were not implemented by members of the family, who stopped coming for treatment. Twelve months later, the family requested a program that worked on skills at a much lower level than initially requested.

REFLECTION

Have you ever been in a situation (either professionally or personally) where someone (who sought your advice initially) has strongly disagreed with your opinion? How did you deal with the situation? How did it make you feel? What were the outcomes?

Consider the family as a whole unit when requesting that strategies be followed up at home. For example, a mother with four young children may not be able to wait for her child who has motor difficulties to dress himself independently in the morning before school. Practice in independent dressing at home in the morning would not be suitable for this family.

It is extremely important to remember that although two children may have been given the same diagnosis, their abilities, needs and skills will be different. A diagnosis does not define the person, but it may give you an idea of difficult areas. For example, in order for a child to receive a diagnosis of autism, he or she would have to have a significant language delay or disorder before the age of three. Therefore you know that the child's language development will be delayed. However, goals and intervention strategies for two children of the same age who have been diagnosed with autism may be completely different.

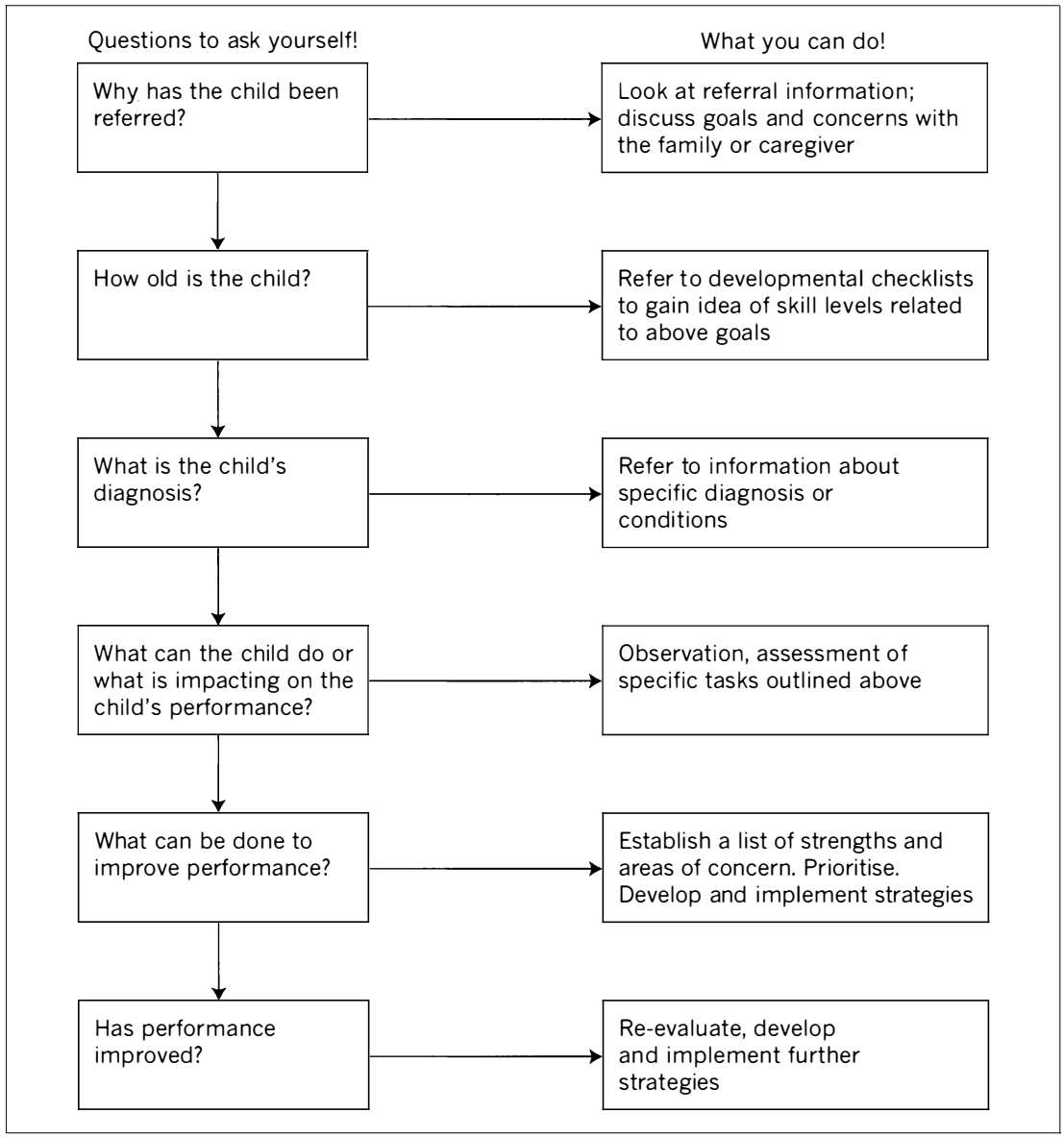
It is also extremely important to focus on children's strengths as well as their difficulties. Assessments tend to focus on the negatives: the things that a child is not doing rather than what he or she can achieve. Many families may be experiencing a range of emotions in relation to the child's disability or condition. Tell members of a family about what their child can do rather than constantly focusing on what the child cannot do.

REFLECTION

Think back to Sarah in the case study. What emotions do you think Sarah's family experienced when they found out that she was given a diagnosis of autism? Would focusing on Sarah's skills have been helpful to the family at this time? Or do you think the family needed time to come to terms with the diagnosis that had been given to their child?

Even the use of developmental norms may not be appropriate for all children. For example, a child with a severe physical disability may never be able to hold a cup independently, so it is not appropriate to compare that child to other children who can achieve this task. It is important to look at what the child is able to do now, the skill that might be achieved and the best way to do this. The flow chart presented in Figure 16.2 could guide you through this process.

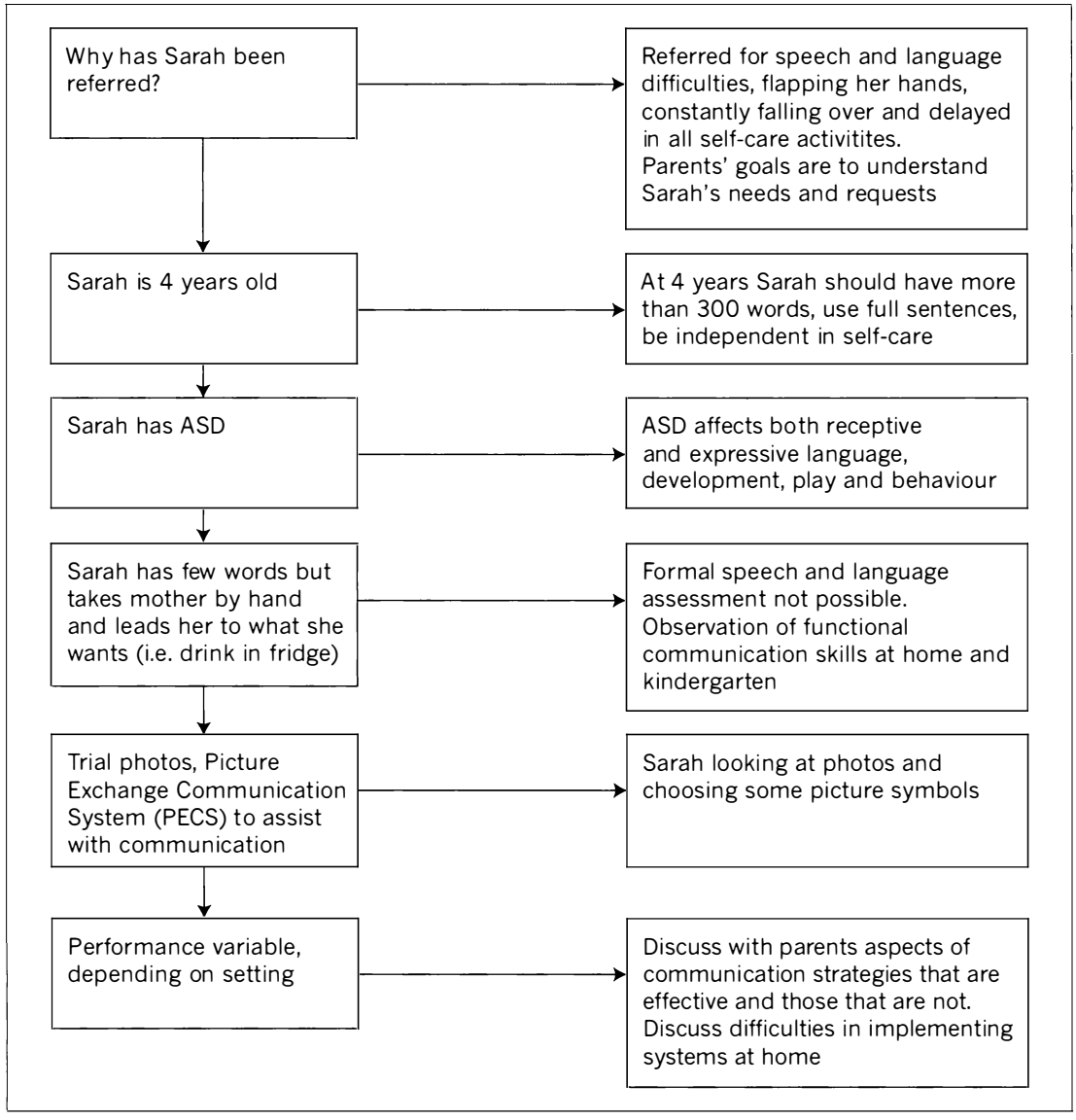
Figure 16.2: Paediatric clinical reasoning process



GENERAL SKILLS AND OTHER IMPORTANT CONSIDERATIONS WHEN WORKING WITH CHILDREN

Working with children and families in a fieldwork placement may be the first time you have worked with or even spoken to a young child—since you were a child yourself! Where possible, take time to observe 'typically developing' children, because this provides you with an opportunity to look at how they interact with each other, the language they use and the activities and games they play.

Figure 16.3: The clinical reasoning process (thinking process) used by the health professional for Sarah



Source: Diagram by Kelly Powell, 2009

It is important to recognise children's ages and abilities so that you are able to communicate on their level. This does not mean that you need to 'talk in baby language' with children who have receptive language difficulties. However, it does mean that you will keep your language brief, use modelling (show them what to do), gesture, get down on their level (sit on the floor or at the table with them) and give them an opportunity to process the information (wait for a response). At the beginning of your fieldwork placement, use this time to observe how your fieldwork educator engages with a variety of children.

Play is the primary occupation for children. Remembering how to play and being playful (using your own personal attributes) will help you to engage with a child. When you first meet a child, find out about his or her interests so that you can integrate those interests in your intervention sessions. This will assist in developing rapport, and help in engaging a child on more difficult tasks (such as colouring in a picture of a favourite TV character as a way of working on pencil control). You will be given more opportunities to do hands-on techniques with children if you are in the later years of your university studies.

The clinical reasoning process

Using the Case Study: Sarah as an example, Figure 16.3 shows you how to think through the paediatric **clinical reasoning** process.

The system shown in Figure 16.3 will help you as a student to understand the strengths and difficulties of the child. It will help you to work through the intervention process and re-evaluate strategies that don't appear to be working. In the case study, it would have been worthwhile discussing the parents' goals and concerns in relation to the intervention before the family felt the need to consult the family service coordinator. Perhaps this would have led to re-establishing strategies and goals to meet the family's and Sarah's needs.

SUMMARY

This chapter discussed strategies that will contribute positively to your fieldwork experience. All children and families are different and you need to respect and value them as individuals. Intervention must focus on the areas that are of concern for families and caregivers regardless of setting. Focusing on a child's strengths as well as areas of concern helps you become aware of how you communicate and engage with children and their families. A diagram outlining the clinical reasoning process—important questions to consider when working with children—was presented, and should be referred to during your fieldwork. Given this information, the fieldwork experience should be invaluable to your career regardless of whether or not you choose to work with children and families.

Discussion questions

1 List the types of fieldwork settings that you may encounter when working with children.

2 Discuss the four skills required in order to become an effective paediatric practitioner.

3 Discuss why observational skills are important. Outline what information you can gain from observation of a child.

4 How is working with children and families different from working with adults?

Portfolio development exercise: Clinical reasoning in a paediatric service

Using the clinical reasoning process chart (Figure 16.2), think about a child that was referred to the service during your fieldwork. Outline each of the steps of the process so that you can fill in each box relevant for that particular child.

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McBride, S. L. (1999). Research in review: family-centred practices. *Young Children*, 54(3): 62–70.

Rodger, S. & Ziviani, J. (2006). *Occupational Therapy with Children: Understanding Children's Occupations and Enabling Participation*. Blackwell, Melbourne.

Stagnitti, K. (2005). The family as a unit in postmodern society. In G. Whiteford & V. Wright St Clair (eds), *Occupation and Practice in Context*. Elsevier, Sydney: 213–29.

CHAPTER 17

Working in Acute Settings

Jo McDonall and Dianne Welch

LEARNING OUTCOMES

After reading this chapter you should be able to:

- identify the types of acute placements and settings
- know how to get organised and prepare for placement
- understand the unique demands of the acute care setting.

KEY TERMS

Acute care setting
Fieldwork placement
Infection control
On placement
Pace of work
Police record check (PRC)
Pre-fieldwork placement
Working With Children Check (WWC)

INTRODUCTION

This chapter is designed to provide you with some useful information to assist in your preparation for fieldwork placement in an acute setting. The skills and knowledge you learn in academic classes provide you with the understanding. Fieldwork placement provides you with an opportunity to assess your ability to demonstrate your knowledge and competence in practice. Regardless of the health course you are studying, fieldwork placement is vital to the development of your assessment, diagnosis and treatment skills, as well as providing opportunity to strengthen your professional communication skills. Fieldwork placement is where all the learning comes together and the relevance of the theory becomes evident.

> Placement is where I learnt what it meant to be a nurse … I had heard all this information in lectures and from my tutors but it only started to make sense when I went on placement and actually saw how the nurse works and what I need to know. (Second year nursing student, 2008)

Healthcare professionals need to develop the ability to learn and flourish in a wide variety of health settings in order to practise in an ever-changing healthcare environment. While preparing for and completing your fieldwork placement, you may find it beneficial to reflect upon how:

- the theory you learnt relates to this fieldwork placement
- to adapt the learnt psychomotor skills to real-life situations
- to assess and modify assessments depending on the client/patient situation or the healthcare environment
- to interpret patient/client information and its significance and whether you need to adapt your plan of care for the patient or client
- the information collected influences your decisions about interventions or suggested care plans
- to integrate reflective practice into your skill set
- to evaluate the care given.

Critically thinking about these points before and during fieldwork placement will enable you to gain the most from these experiential learning opportunities and be proactive in your professional development. It is important that you are well prepared for fieldwork placement so that the experience is positive, and you take as many opportunities as possible to contribute to client or patient care. The following tips are provided to assist you in your preparation for fieldwork placement in an acute setting. The list is not exhaustive—you may know of other tips, and we encourage you to share these with fellow students.

TYPES OF ACUTE FIELDWORK PLACEMENTS AND SETTINGS

The setting of your acute clinical fieldwork placement will depend on the discipline and the specific course requirements. Sometimes fieldwork placements occur intermittently, such as for one or two days per week over an extended period of time, or in blocks of time of perhaps two weeks to several weeks' duration. Other considerations will be the availability of clinical resources and the degree of supervision required for patient or client safety. Acute fieldwork placements may be in settings such as:

- metropolitan hospitals
- private hospitals
- rural or regional hospitals
- medical clinics
- patients' or clients' homes (hospital in the home).

Initially you may have minimal responsibility in terms of patient or client care, as the fieldwork educator may take most of the responsibility. However, as you progress in your course, you assume more accountability for your patients' or clients' care, and your interactions with them will also subsequently increase. For instance, in your early placements

the emphasis may be on your familiarisation with professional roles and responsibilities of your chosen discipline, the healthcare sector, policies, procedures and services. However, you must always remember that, even though you may not have the majority responsibility for the **acute care** provided, you do have an obligation for implementing skills and knowledge learnt in your academic program in a safe and competent manner that supports quality patient outcomes and patient safety.

REFLECTION

AN ACUTE CARE SETTING

You have been assigned to begin in an acute care setting for your fieldwork placement. Reflect on what you are expecting about the pace of work. What do you understand as the demands on staff on the wards? How do you feel about encountering very ill people? What are your strengths, or areas for improvement?

GETTING ORGANISED: PRE-FIELDWORK PLACEMENT

In order to get the most from your acute fieldwork placement it is important that you are prepared. This section will provide some useful tips about what is important for you to know before your fieldwork placement commences.

How do I get there, and then what?

Transport

Preparation begins before the commencement of your fieldwork placement. The better prepared and informed you are about the expectations of the placement—even about where to park the car—will reduce the stress that you might otherwise experience. Many acute settings are in large busy hospitals: know where to park or what public transport to take, the building to go to, and how to find the department or ward you will be working in. If you are unfamiliar with the health agency, go for a pre-fieldwork test drive, or take public transport at the same time you will be going on the same sort of day so you can anticipate how long it will take you. This ensures you know how to get to the venue and how long the journey may take. Find out the cost of driving or taking public transport, and how far you need to walk from the car park or bus or train stop, and whether the venue is accessible and safe at night. It is important not to be late when you commence your placement. It is your professional responsibility to ensure you present on time for your placement.

THINK AND LINK

Chapter 1 outlines how to prepare for your fieldwork placement. You might like to review this chapter, then consider the differences between preparing for an acute hospital setting as opposed to preparing for a community-based setting. What is similar? What is different?

Preparation sessions

For some disciplines, you may be required to attend fieldwork placement preparation sessions, which may be tutorials or sessions organised by your university or the host healthcare agency. These sessions will provide you with essential information about expectations, learning outcomes and key contact personnel and also those day-to-day bits of knowledge that make the fieldwork experience feel positive, such as lockers for your personal belongings, where to meet on the first day, perhaps the designated area that you will be assigned to for your fieldwork placement and even where the cafeteria is located. Maybe you will have access to a small kitchen to store your meals. If lockers are available, it is advisable not to take any valuables while you are on fieldwork placement, as valuables can be lost or damaged. Alternatively, this type of information may be made available to you via online resources.

It is important that you are familiar with assessment expectations throughout your fieldwork placement. You need to make sure you are familiar with any fieldwork placement rules that govern your placement and also obtain copies of these and any competency assessment tools or competency standards that you will be assessed against throughout the placement.

THINK AND LINK

Chapter 6 is about assessment within fieldwork placements. Knowing how you will be assessed within an acute setting will assist you to focus on your learning goals. Learning in a fieldwork placement involves more than skills and tasks. What do you want to learn from your fieldwork placement in an acute setting?

The venue

On a pre-fieldwork visit, you may have an opportunity to find out about the ward areas: patient or client profiles, any important pre-reading that may assist you in understanding patient profiles, drugs used and services provided by the institution you will be working in. Other information you may want to obtain on your trial visit to the venue is the emergency numbers or procedures of the venue. Contact your fieldwork educator before your visit to introduce yourself and make arrangements. He or she may request to meet you and accompany you on your orientation.

Specific ward orientation may include the type of ward or area you will be placed on, such as an orthopaedic ward or the outpatient physiotherapy department, or reading up on or revising your lecture notes, unit materials, specific ward or venue information. This will refresh your learning and give you confidence about expectations and an ability to answer questions that the fieldwork educator will pose to you. Depending on your discipline, before placement it may also be important for you to revise information about common drugs and procedures or surgeries that you may encounter in the department. This information may be available at the **pre-fieldwork placement** information sessions. If this information is not given before placement, ask questions of your lecturers or fieldwork educator.

Goals and objectives for placement

Often students arrive on the first day of fieldwork placement unsure of the learning objectives for the placement or what they want to achieve. Valuable time can be lost if you need to discuss at length your goals and objectives with the fieldwork educator. This is also very frustrating for fieldwork educators, as it can distract them from meeting their own responsibilities. It might appear that you are not interested in the placement because you have come ill prepared. Therefore, in order to get the most out of your placement, consider before placement what your specific goals and objectives are and how your theoretical program relates to these objectives and goals. The learning outcomes, objectives and goals will often be derived from current units of study or overall course objectives and aims, such as being able to perform a particular complex task or to develop an understanding of specific conditions or situations. If you require assistance with establishing goals for placement discuss this with your tutorial leader or academic in your university.

Be prepared with the right documentation

As you are a health professional, it is important that your immunisations and any other health department requirements are up to date and that you have documentary evidence of your health status. Each state and territory will have individual requirements, so it is important to note that if you cross state and territory borders you are familiar with the requirements of all jurisdictions.

Immunisation requirements may vary slightly between acute care settings, so you need to check with your university clinical coordinator to make sure you are aware of any additional immunisations you may require. The Victorian Government provides a list of the common vaccines you will require (see www.health.vic.gov.au/immunisation/resources/health-care-workers-guide.htm). You will need documentation with you during the placement that you have had these vaccines. The acute care staff can ask at any time to make sure that you have been immunised. If you have had your immunisations but do not have a record of them, you will need to speak to your academic clinical coordinator or campus nurse/doctor to discuss alternatives (such as a blood test).

In Victoria, the Department of Health also requires you to provide a Victoria **Police record check (PRC)**. This can be obtained via: www.police.vic.gov.au/content.asp?Document_ID=274.

You must have a current NPRC at the commencement of every year of your course. Agencies can refuse to take you for placement if you cannot produce a current NPRC.

The Justice Department requires that you also provide a **Working With Children Check (WWC)**. This check is required for any student who may come into contact with children while on clinical placement. The WWC will last for five years. The following link takes you to the WWC site: www.justice.vic.gov.au/workingwithchildren.

You may also be required to provide your school with consent forms or other documentation prior to an acute clinical fieldwork placement, so check with your clinical coordinator or administrative staff at the commencement of the trimester.

THINK AND LINK

Chapter 2 discusses your responsibilities for your fieldwork placement. More information on police checks and Working With Children Checks are given in this chapter. Why do you think a police check or a working with children check is necessary?

Looking good

All students must maintain a professional appearance while on fieldwork placement. You will need to make sure you have the appropriate uniform, as approved by the university. You will also need a student identification card that clearly states what university you are from and that you are a student. If a particular acute placement requires alterations to dress, students will be notified prior to the commencement of that placement. In line with Occupational Health and Safety policies, no jewellery is to be worn (except for small ear studs), long hair should be tied back and fingernails short, clean and free from nail polish.

Take time to go through the information presented in Table 17.1. Tick off what you have prepared, and note what you need to prepare, before you begin your acute care placement.

Table 17.1: Preparation list before beginning an acute care placement

Information required for placement	Tick	Notes
Agency/facility: Name/address/contact details Transport/parking/cafeteria Ward/unit name/location/contact details Look at website/emergency procedures		
Type of acute placement (e.g. hospital/community/rural)		
Duration of placement		
Shift times/your roster/work times		
Uniform requirements		
Pre-reading of agency requirements		
Review university objectives and rules for placement		
Objectives for placement—what competencies do I need to focus upon for this placement?		
Review unit material relevant to ward or placement area		
Clinical facilitator/teacher's name/contact details		
Place to meet (orientation) on day 1		
What I need to take: Uniform Identification badge Pen/watch/stethoscope/calculator Other items advised by agency Clinical assessment tool Other relevant assessment tasks Learning objectives Any other documents as advised by your school		

SUPERVISOR PROFILE

CAMILLA MCELHONE

Camilla works at Epworth Hospital's speech pathology department, which consists of a team of speech pathologists who graduated from a variety of universities from around the country. She and her colleagues work across five different campuses in Melbourne, covering the continuum of care from emergency department to acute wards, inpatient rehabilitation and outpatient specialist care for adults with acquired speech, language, swallowing and voice disorders. Camilla graduated from Sydney University in 2007 and has been working as a speech pathologist for five years.

1 *Tell us about your role. What does a typical day involve?*

I work as a speech pathologist at Epworth Richmond which is an acute hospital equipped with quality facilities and latest technologies including a 15-bed Intensive Care Unit, and eighteen operating theatres. With close to 42,000 admissions, more than 1500 staff members and 1200 accredited visiting specialists, Epworth Richmond is a leading healthcare provider in Australia.

The acute speech pathology role involves the assessment and management of adult clients with acquired speech, swallowing, voice and communication changes. The majority of clients have changes to their communication or swallowing due to neurological events, progressive neurological diseases (e.g. MS, PD, dementia), or resulting from complex medical or surgical illness, e.g. cancer, respiratory illness.

Every day is different and due to the nature of the acute caseload I reprioritise constantly throughout the day. You never know when you will need to drop everything and race to ED to see a new stroke patient or head to ICU to a patient with a tracheostomy or back to the ward to educate staff on your patient who has had a laryngectomy. However, a typical day involves:

- meeting with the acute speech pathology team and prioritising patients for the day
- going to the acute wards to see patients for assessment or intervention, meeting with families or other health staff (doctors, nurses, other allied health)
- doing a joint session on the ward with the dietitian or with an OT or PT
- conducting a videofluoroscopy or see a tracheostomy patient depending on what patients are on my caseload for that day
- working on a quality project or attendance at service development meetings within the speech department or the wider hospital
- attending professional development.

2 *What are some of the challenges you face as a clinical supervisor?*

Time is always a challenge; some days you may be run off your feet and struggle to fit everything in. On other days you have more time to do non-clinical work and build relationships. Staffing can also be a challenge. If people are unwell or on leave everyone pitches in to help out.

It is important for students to be well organised and prepared. This will help reduce stress and enable you to be more flexible for the day.

3 *What is unique about this setting in terms of student supervision?*
At Epworth you will have a sole supervisor but also have the opportunity to work with all the speech pathologists across the acute and subacute setting. You may also have the opportunity to work across other sites related to the hospital.

4 *What clinical skills are important for this setting?*
Important clinical skills are:
- good rapport building skills
- open and honest communication to other staff and to patients and families
- being accountable for your work and what you say you will do
- meeting timelines
- asking for help when you need it
- discipline-specific assessments
- ability to implement strategies and intervention with guidance from your supervisor.

5 *What preparation is expected on of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*
Speech pathology students should be familiar with oromusculature assessment. They need to know the cranial nerves involved in speech and swallowing, and know and be able to distinguish—dysphasia, dysarthria, dysphonia, dysphagia. Some familiarity of assessment for swallowing and communication and knowledge of the normal swallow anatomy and physiology is important.

While the above is an example from speech therapy, you will need to contact your fieldwork educator about the specific preparation you need in your discipline.

Revise your lecture notes. Your placement supervisor may send you prerequisite readings. Make sure you complete these.

The following texts will be useful if you are a speech pathology student:
- Brookshire, R. (1997). *Introduction to Neurogenic Communication Disorders* (7th edn). Mosby Elsevier, St Louis.
- Crary, M. & Groher, M. (2003). *Adult Swallowing Disorders*. Butterworth Heinemann, St Louis.
- Duffy, J. (2005). *Motor Speech Disorders; Substraites, Differential Diagnosis and Management* (2nd edn). Mosby Elsevier, St Louis, USA.
- Logemann, J. (1997). *Evaluation and Treatment of Swallowing Disorders*. College Hill Press, San Diego.
- Webb, W. & Adler, R. K. (2007). *Neurology for the Speech Language Pathologist* (5th edn). Mosby Elsevier, St Louis.

6 *What are some of the key learning opportunities available to students?*
- Students will learn how to conduct a thorough assessment in their discipline area.
- They will learn how to assess and manage a range of deficits.
- Videofluoroscopy or discipline-specific instrumental assessment observation.
- Tracheostomy or discipline-specific management observation.
- The opportunity to participate in adult rehabilitation.
- Quality projects.
- Interdisciplinary teamwork.

7 *What would you expect from a final year student on placement?*
- A professional attitude, strong communication skills and an appropriate level of independence.
- A student who looks for their own answers before asking. At least you can then say 'I've looked into dysarthria assessment and found this, this and this. What do you think would be the best assessment to use'.
- To be able to read through a medical history and give an overview of the patients admission, past medical history and preadmission level of function.

8 *What parts of the placement could students find challenging? What tips do you have for them?*
- Time management is a challenge, I would recommend keeping a diary or timetable and talking to your supervisor about including time for administration and statistics.
- Hospitals have people who are very unwell. This may be confronting for some people. If you have had a family member or friend who has been unwell and in hospital you should talk about this with your supervisor at the beginning of your placement so we can choose appropriate patients for you to see.
- If you have any injuries or medical conditions let your supervisor know so they can organise your day accordingly.
- We don't expect you to know everything. It's okay to say 'I've never heard of this' or 'I don't know what this means' but it will impress your supervisor if you have a go at looking it up yourself first and then speaking to them.
- Keep your folder organised with things you need for the day. Divide it up into sections e.g. for speech therapy this would be OPE, dysphagia, speech, communication, etc.

ON PLACEMENT... HELP

It is normal to feel a little nervous or apprehensive on your first day. Understanding what is expected from you as a student on your first acute care placement will go a long way to help relieve some of the anxiety.

Emma, a second year Nursing student, recalls her first acute care placement:

> I remember having to wait in the foyer for the clinical teacher ... I was so early because I didn't want to be late on my first day, but waiting around made me a little more nervous. I remember thinking: what is my clinical teacher like? Will she think I'm okay? What will the ward be like that I'm going onto? Will I know enough to look after the patients there?

It is important you arrive a little early for your first day of fieldwork placement. You will be expected to meet your fieldwork educator or hospital representative at a designated place, or you may be directed to go straight to the ward or unit or department you will be working on.

In acute care settings, you need to be prepared for the following: the **pace of work**; strict adherence to infection control; patient stress; and communication.

Pace of work

Things move fast in the acute setting. Patient or client movements are happening all the time. Some patients may be arriving back to the ward after procedures; some are being discharged; and as you discharge one, another is waiting to be admitted. Often there are many responsibilities that you will be required to demonstrate competence in such as patient assessments, medication administration, preparing a patient for operations or admission reports.

As a student this can lead to you feeling a little lost at times. Remember to allow yourself to be a student: it is okay to sit and read a patient's or client's notes, watch procedures being performed and take the time to talk to your patients or clients. Always be on the lookout for learning opportunities. If you see something that you would like to do, for example, complex wound management, take the initiative! Go home that night and read all you can about complex wounds. The next day you can ask if you can undertake the dressing with supervision.

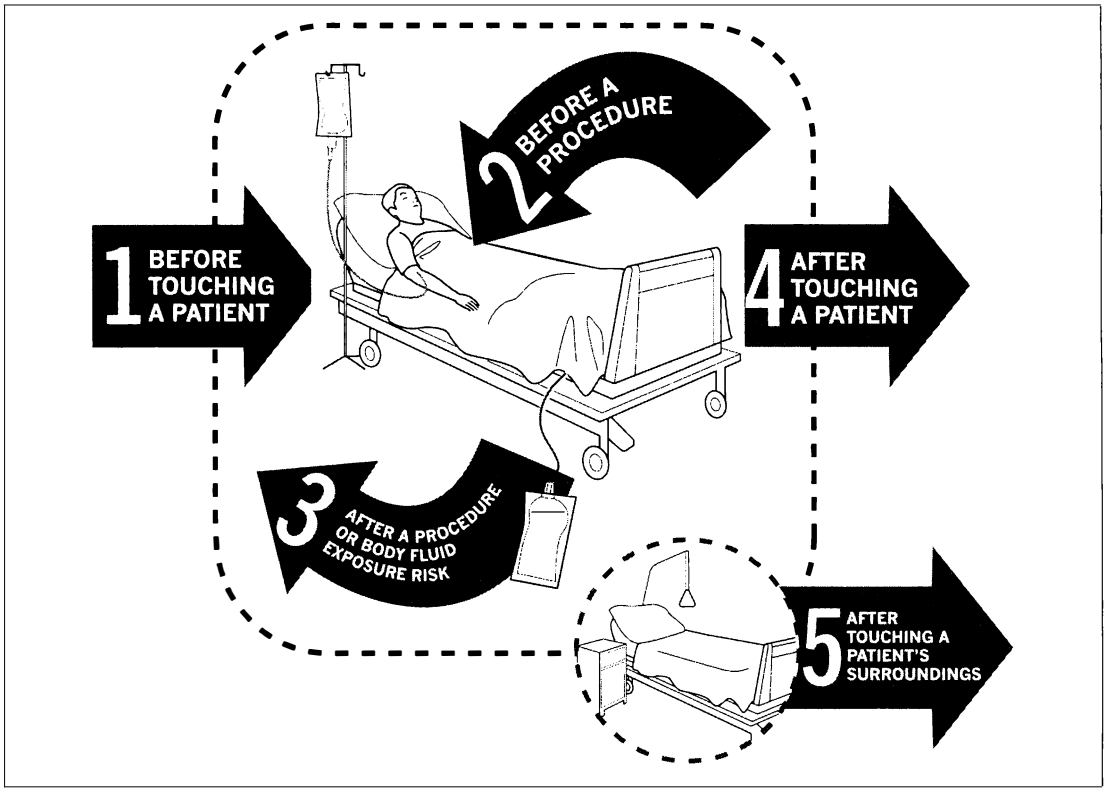
Work intensity

The past decade has seen increasing patient acuity and shortening lengths of stays in acute care hospitals. This has intensified the work for the staff in acute hospitals. You will be confronted with varying degrees of illnesses, from major traumas or illnesses to minor procedures that only require a brief admission. With the reduction in patients' length of stay in acute care facilities, the stress for the healthcare staff has increased, as they seek to ensure that patients are provided with appropriate learning opportunities and information regarding how to care for themselves when they are discharged home. To assist you in preparation for your fieldwork placement in an acute setting, learn about common conditions specific to the area you are going to, understand how to manage them and what skills and knowledge will be necessary to provide safe patient care.

Infection control

Infection control practices protect both the patients and you! Patients are at risk of acquiring infections in the healthcare environment because of lower resistance to infectious agents and an increased exposure to disease-causing microorganisms. Ensure you protect yourself and your patients by wearing gloves when coming into contact with body fluids. Wear goggles when there is a risk of splashing. Personal hygiene practices are necessary to ensure you do not transmit infections: frequent hand washing is crucial in ensuring you do not transmit infectious agents. Make sure you are familiar with the occupational health and safety guidelines for infection control in the area you are working in. Familiarise yourself with the Hand Hygiene Australia website (www.hha.org.au/home.aspx), and remember the '5 moments for hand hygiene' (see Figure 17.1).

Figure 17.1: The 5 moments for hand hygiene



Based on the 'My 5 moments for Hand Hygiene': www.who.int/gpsc/5may/background/5moments/en/index.html © World Health Organization 2009. All rights reserved

Communication

Talk to all the staff in your team. Relating to the interdisciplinary team (doctors, physiotherapists, nurses, dietitians, speech therapists and occupational therapists) can be daunting. Knowing who to talk to about specific questions is one key aspect of learning in the clinical environment. Observing how your fieldwork educator interacts with this team will enable you to learn how to communicate in various situations. Effective communication is a skill that you will develop with experience. Use your fieldwork placement time to improve how you communicate with colleagues and the interdisciplinary team, and with patients and their families. Don't forget to smile; this not only helps your patients feel better but also others in the team.

THINK AND LINK

Communication between members of an interdisciplinary team is important for the care of patients. Chapter 8 discusses interprofessional practice and highlights the importance of teamwork.

CASE STUDY

What a day!

Jill was in her final year. She was confident and organised. She had worked in community-based settings, a private practice and an aged care facility. This placement was her first acute setting in a large busy hospital. She had made a pre-fieldwork placement visit and was on time with all her documentation. She had planned out her first day in her head. However, when she arrived at her placement, there was a Code Blue being called out over the speakers and staff were rushing everywhere. She was ushered into a room and told to stay there and wait and the door was closed. She waited for over an hour! Eventually, someone came and took her out of the room to orientate her to the ward where she was going to stay for the duration of her placement. She was annoyed that one hour had been wasted of her time but also frightened about the events that had just occurred. She said so to her fieldwork educator. The day didn't go as planned. Events moved quickly; tasks had to be completed without the time for preparation she was used to. She felt as if she were drowning.

QUESTIONS

1 What had Jill not understood about an acute care setting? What had she not prepared for?

2 How could her fieldwork educator help her understand the demands of this particular setting?

Emergencies ... what do I do?

At times you may be involved with unexpected events or emergencies, such as a cardiac arrest or a patient fall. You must be familiar with the emergency codes and procedures of the agency where you are on placement. The emergency codes will be explained to you on the first day. However, it is your responsibility to ensure you know the different codes and what they refer to. If there is an emergency on your ward you may be expected to assist where necessary, therefore you must be familiar with the emergency telephone numbers, any evacuation procedures and or emergency procedures and equipment locations in the unit.

Emergency codes can vary slightly between organisations. *It is imperative that you familiarise yourself with the codes used in the organisation where you are on placement.* Some common codes you are likely to hear in the acute setting are:

- Code Red: fire or smoke discovered
- Code Orange: evacuation procedure when instructed to do so
- Code Purple: bomb threat
- Code Black: personal threat (police assistance required)
- Code Grey: patient threat (patient-initiated violence)
- Code Blue: medical emergency
- Code Yellow: internal emergency
- Code Brown: external emergency.

CASE STUDY

It's all in a day

David was placed in a day surgery ward on his first day. That's where he would be working for the whole of his time on placement. Patients came in at 7 a.m., had surgery and were discharged at noon. The second group of patients would come in at 12 noon, have surgery and be discharged at 5 p.m. the same day. He was not used to such a large turnover of patients, and sometimes felt that his patient care was dictated by the institution and not by the needs of the patients. In his course he had been taught about patient-centred care and always working with patients or clients and their needs. But here, in this placement, people went in and out. He hardly had a conversation with any of them, let alone knowing their goals, needs and who they were, and whether they required any other services, such as community-based care. They were just conditions that came through the door, and four to five hours later left through the same door.

QUESTIONS

1 In such a setting, how do you combine patient-centred care with the pace of work? Is it possible?

2 How do you cope with the clash of cultures; that is, the culture you were taught to work in and culture of the actual workplace?

REFLECTION

AN EMERGENCY

What are you like in an emergency? How do you behave? If you are not comfortable with dealing with emergencies, what are some strategies to help you to cope?

SUMMARY

This chapter has provided you with some useful tips to help you get ready and survive your first acute fieldwork placement. Pre-planning is important for fieldwork placements in large metropolitan or rural hospitals, and pre-fieldwork visits will help you to orientate yourself to the geographical location, the wards or departments you will be working on, and how to get around the physical setting. Undertaking a placement in an acute setting, you will learn about infection control, adjusting to a faster pace of work, coping with emergencies and communication with other staff. Acute care can include hospital in the home, day surgery and in-patient wards. You need to be well prepared and open to learning.

Discussion questions

1 How would you best prepare for your first acute fieldwork placement?

2 What are your expectations when undertaking placement in an acute care setting?

3 What would your learning goals be in an acute hospital setting?

Portfolio development exercise: Demonstrate your competence

This chapter has provided you with important strategies to prepare for and facilitate your learning opportunities while completing your acute care clinical placement. Much of the information in this chapter relates to processes or procedures. You might like now to reflect upon how you will demonstrate your competence, and the application of knowledge and skills learnt at university to ensure safe, quality care while completing your acute care placement.

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USEFUL WEBSITE

Hand Hygiene Australia: www.hha.org.au/home.aspx

CHAPTER 18

Working with Older People

Jennifer Nitz

LEARNING OUTCOMES

After reading this chapter you should be able to:

- know where older clients will be encountered, and about the interdisciplinary team that manages older people
- understand the importance of a person-centred approach to client management
- know your role as a student when participating in fieldwork placement with older people
- understand the importance of communication, interpersonal skills and body language in clinical practice
- discuss the framework for practice
- discuss the impact of age-related changes on all aspects of geriatric practice and the depth of knowledge needed to practise effectively
- articulate where health promotion and preventive interventions fit.

KEY TERMS

Chronic condition self-management program (CCSM)
Communication
Geriatric care
Health promotion
Work-integrated learning

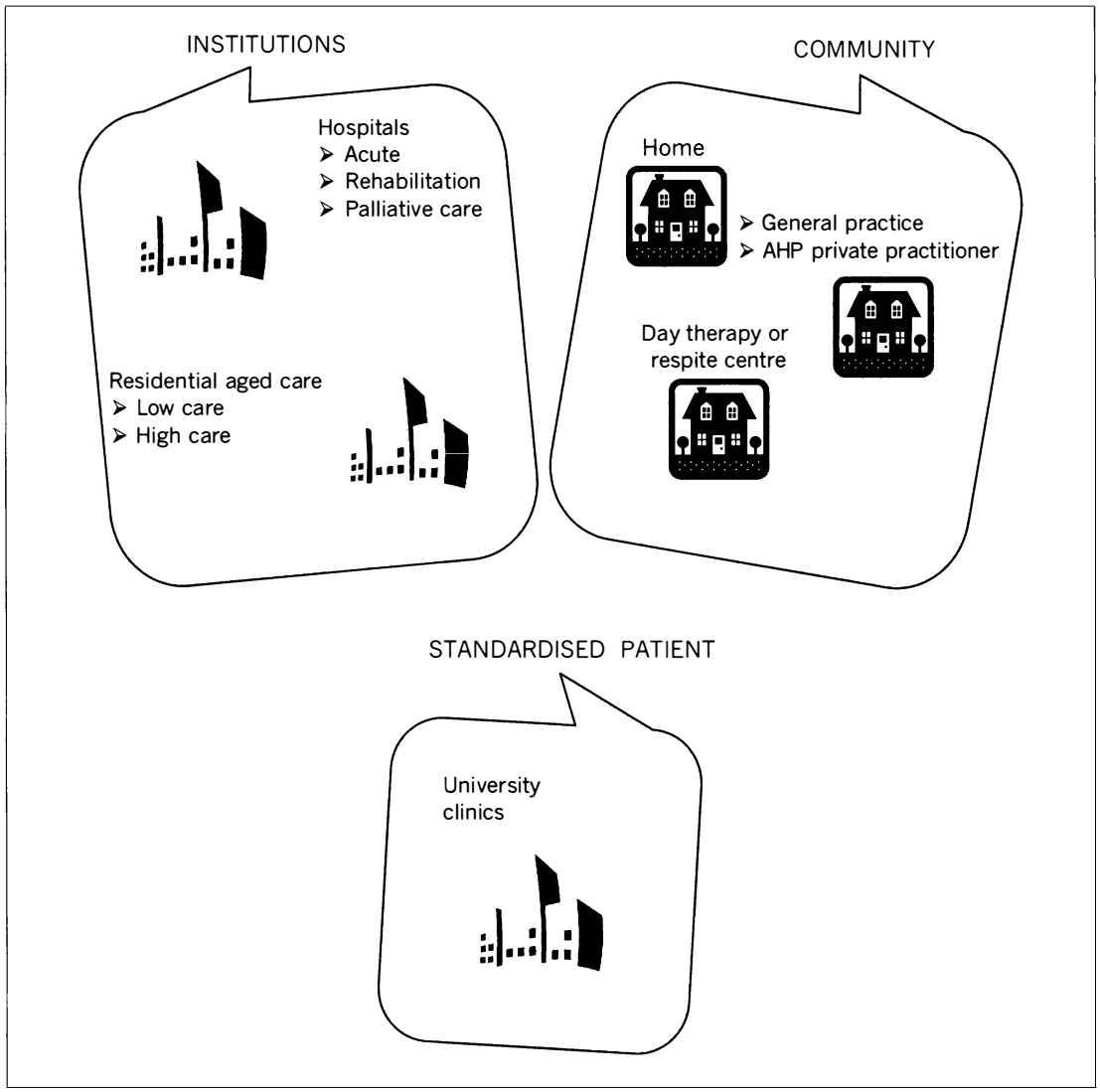
INTRODUCTION

Geriatrics is 'a branch of medicine or social science dealing with the health and care of old people' (*Australian Oxford Dictionary*). A common misconception of working with older people (**geriatric care**) is that the experience will be encapsulated into a single placement. In fact, you will encounter older patients or clients in most of your fieldwork placements, not just

during a defined geriatric placement. Most students will experience fieldwork placements in an institution or community. Figure 18.1 illustrates the scope of fieldwork placements when working with older people.

When working with older people during your fieldwork placement you will be part of an interdisciplinary team that includes patients, their significant others, doctors, nurses and a combination of allied health professionals. The team members will be determined by the condition of the patients, and will vary across the timeframe as the needs of patients are likely to change with their medical status. The most crucial aspect of team efficacy is communication among the team members and ensuring that the health professional who is most suited to attend a particular aspect of treatment provides that treatment. For example, treatment of pneumonia with assisted secretion removal is provided by the physiotherapist who has specific training in the techniques required for that treatment, as well as the capacity to evaluate and modify interventions as indicated by the patient's condition. This skill is profession specific, just as changing wound dressings is a nursing skill and treating speech problems is speech pathology specific.

Figure 18.1: Scope of fieldwork settings when working with older people



Irrespective of the environment in which you experience fieldwork placement with older people, the same broad expectations of you will apply. In 2007, 1.6 per cent of the population of Australia was aged over 85 years, with those aged over 65 years comprising 13 per cent of the population. Working with older people could comprise a large proportion of your practice, irrespective of profession since older people are more likely to need care provided by health professionals as a result of acquired age-related morbidity and pathology. This complexity of presentation is what makes working with older people exciting and challenging. No two adults will be the same, so strict adherence to protocols for managing a particular diagnosis become fraught with danger. Having said that, there are principles of assessment and management that form a framework for therapeutic interaction with the elderly that you will morph and colour with the information you gather during interviews, physical, cognitive and social assessments, problem identification, goal-setting and treatment, thereby developing an individualised management plan. This chapter endeavours to assist you to broaden your horizons and develop excitement about and commitment to the care of older people through demonstration of **work-integrated learning** in fieldwork placement. Working with older people is very rewarding, presenting a constant challenge to your inventive initiative and continued professional development.

PREPARING FOR WORK-INTEGRATED LEARNING WITH OLDER PEOPLE

Older patients in hospitals, residential care and community commonly have multiple, complex and chronic conditions, and what you learn from these encounters is priceless. If the content and context of exposure to geriatric clients during fieldwork placement is not well supported by clear learning objectives and your fieldwork educator does not facilitate your understanding of the relevance of information and experiences in the context of professional practice, it is likely that this will discourage you from working in settings with older people. Powers and colleagues (2005) found that such negative experiences led students to avoid working with older people after graduation.

Flexibility and being able to respond to the guidance provided by individual patient responses is vitally important for practice with older people. Remember, every person is different. This is why the clinical reasoning processes you utilise during your interactions must be patient centred and patient driven. This means that the patient's presentation and presenting problems will be the guide to your assessment and treatment approach, together with the patient or patient's carer suggestions about their own goals.

Preparing for fieldwork placement where older people will be encountered depends on which year of your studies you have reached. Most placements will demand a variety of levels of knowledge expectation and education objectives and goals commensurate with theoretical knowledge preparation. If you are lucky, you will undertake fieldwork with older people in every year of your study program. This will enable you to develop competencies in communication, assessment and intervention appropriate for the older person. If your fieldwork exposure is limited to the final years of your study, then expectations for participation in practice will be greater. You will be expected to achieve basic practitioner competency by the completion of the placement. The basic competencies for practice

should be found on your professional association website. You are encouraged to consult this information in conjunction with your course outcome expectations to map how you are acquiring the profession-specific skills for independent practice.

Fieldwork contract

When you arrive at your fieldwork placement you may draw up a contract with your fieldwork educator. It will identify the necessary, desirable and wish-list experiences you should achieve by the end of the fieldwork placement. If such a contract is not formally made, it is a good idea to itemise all the aspects of work with geriatric or older clients that you would like to encounter. Negotiate with your fieldwork educator opportunities to participate in the experiences you have identified. Remember that you might have to fulfil your wish list over a few fieldwork placements. For example, if acute condition management is not available in the facility where you are undertaking your geriatric fieldwork, you could arrange a visit to another facility, or consider this aspect of working with older persons if available in another placement.

Framework of fieldwork placement

To gain most from your fieldwork placement with the older person, it is essential that you have a thorough understanding of the framework for geriatric practice. This framework includes:

1. *Communication*: Primary **communication** is between you and the patient. Additional information might be gained by sharing information regarding the patient with other team members via patient medical files and by talking with the patient's family or carer. The information from family and carers is often needed to validate the information gained during patient interview when cognitive decline is suspected or known.
2. *A broad knowledge base of 'normal' ageing and pathologies* (Nitz & Hourigan 2004) likely to be encountered should have been included in your pre-fieldwork preparation. If not, you will find it beneficial to access normal age-related data from the literature regarding outcome measures that are pertinent to your field of practice: for example, normal performances for clinical balance measures as provided by Isles and colleagues (2004). Ideally this theoretical knowledge would include palliative care and information regarding advanced healthcare directives otherwise known as living wills or end-of-life directives.
3. *Competency in application and interpretation of profession-specific skills*:
   (a) ability to assess the older person (using, for example, balance tests and body system assessments) and interpret the results
   (b) ability to develop treatments specific to the condition and the person.
4. *Utilisation of clinical reasoning skills* to enable effective patient-centred problem-solving and goal-setting.
5. *Empowerment of patients* to gain or retain self-determination through goal-setting, and full participation in and implementation of their treatment plan.
6. *Effective measurement of outcomes* through re-evaluation of older people, at intervals appropriate to the acuity of their problems.
7. *Consideration of* **health promotion** *and prevention* of age-related decline or complications of current morbidities to ensure preservation of independence and quality of life for the patient and carers.

8 *A willingness to investigate and learn independently*, as indicated by an openness to exposure to medical conditions not previously encountered, new social attitudes and expectations and the ability to adapt intervention strategies to the cultural, physical and cognitive abilities encountered in older people.

Successful learning and professional development in the field of geriatric practice requires you to integrate many theoretical and practical skills that will have been or will be addressed during your student training.

REFLECTION

PREPARING TO WORK WITH OLDER PERSONS

What are the important steps you should take in preparing for a fieldwork experience where older people will be encountered? Do you need to prepare for a geriatric fieldwork placement in an acute hospital ward any differently than you would prepare for acute ambulatory care or residential aged care?

COMMUNICATION IS MORE THAN JUST TALKING

Communication may take the form of spoken words, written words or drawings, gestures, demonstrations or sign language. It might take place through face-to-face contact, through videoconferencing, or telephone, email or mail hook-up.

Form of address

A respectful form of address when working with older people, their families and carers is mandatory. On initial contact, and during subsequent meetings, until and unless the patient or family member has sanctioned change, you should address your patient as Mr Jones or Mrs Jones, not Bill or Jill. Verbal interaction during interview, social discourse and treatment or intervention should not use complex medical terminology or phrases. Ask your patient if they understand what you have said or whether they need more explanation. If you are still concerned about whether they understand, ask your patients to tell you what you have been discussing with them.

Types of contact

Get down to eye level when talking with your patients. Non-verbal communication is very useful in enhancing understanding and retention of the spoken word. This might take the form of written instructions, drawings or gestures as a way of demonstrating what you want your patient to do. This is particularly important when working with people with receptive problems caused by stroke and aphasia or dementia.

Body language indicates whether you are interested or uninterested in what is happening with older people. Poor or uninterested body language is a common reason why

patients lose interest and motivation to participate in their treatment. Similarly, patients' body language tells you a lot about how they feel. If they are depressed or in pain their demeanour will lack affect and motivation, and sometimes your patient may cry. Therefore listen to your patients and their families and carers. Patients will tell you what their problems are, which in general will indicate the goal for treatment. If you disregard this information it is very unlikely that patients will comply with your treatment.

Communication interference

A number of factors might interfere with communication between you and your patients. Impaired hearing is very common in the elderly. Find out if the patient has a hearing aid, then encourage its use. Make sure the patient can see your face clearly, so lip reading, facial expression and gesture can be used to augment what is heard. Where English is not a patient's first language, he or she may not understand complex questions or instructions, or you will fail to find out important assessment facts, and will achieve only poor treatment outcomes. Always avoid excessive use of medical jargon, for the same reason.

Client and carer education comprises a major part of your work with older people. When you are treating the patient, it is pertinent to educate clients and carers as to the reason for the treatment. Education on preventive health components is especially important for carers in order to prevent them becoming injured or sick, which could stop them continuing as carers.

THINK AND LINK

Sometimes when English is not the person's first language, a translator may be included in the assessment and/or treatment sessions with older people and their carers. Chapter 14 gives details of what to consider when working with translators and diverse populations.

REFLECTION

COMMUNICATING IS MORE THAN VERBAL

Try instructing one of your family members or friends who is not a health professional to do a task that is novel for them. How do they respond? Reflect on how could you clarify your instructions so they understand more readily what you want them to do. Reflecting on your communication skills in this instance will greatly benefit your fieldwork practice.

Body language

Some elderly patients are affected by medical conditions that interfere with their capacity to understand the spoken word. People who have suffered a stroke that has caused right side hemiplegia often have aphasia, which interferes with understanding what has been said. People with dementia or delirium might also have difficulty in interpreting the meaning of

words, and so respond to instructions in ways that are not anticipated. An example of this is when a person with dementia is asked to step backwards before sitting in a chair. 'Backwards' is a concept that has been lost, so the person will likely step forwards, as the only word understood is 'step'. You will succeed if you stand beside the person, then step back while gently guiding the patient back and saying 'step back'.

Engagement with the elderly patient is communicated through facial expression and other caring actions. Boredom and lack of interest is quite evident to older people, who will respond in like manner by not wanting to help themselves or participate in their treatment. You need to show that you are enthusiastic and happy in order for your patient to benefit. Such behaviour will enhance your own learning capacity, so you will start to become a more independent learner and a much better practitioner.

Confidentiality and consent

Members of the care team must consider respect for privacy and confidentiality of personal information when caring for older people. You need to always be aware of how and where you discuss patient information. It is best practice to keep case discussions to non-public areas so that this aspect of privacy is respected. Gaining informed consent regarding treatment is mandatory, and hinges on good communication between the treating team and the patient. Consent may need to be sought from a patient's guardian when cognitive impairment or unconsciousness is present and renders the patient unable to provide personal consent. Only the person who has been given the legal right is permitted to provide proxy consent. You are encouraged to undertake independent enquiry into this topic.

THINK AND LINK

Chapters 12 and 13 discuss ethical issues health professionals encounter when working with vulnerable populations. As people age and become frailer and/or have cognitive decline, they become more vulnerable to being misled or abused. When reflecting on ethical practice with older persons, don't forget to read Chapter 12.

SUPERVISOR PROFILE

JANET COBDEN AND CAROL PARKER

Janet is a Senior Clinician in Geriatric Physiotherapy at a regional hospital in central Victoria. She does similar work at a small rural hospital, Inglewood and Districts Health Service, one day per week. Her work is with the Transition Care Team as a physiotherapist assisting patients in their move from hospital to home. Janet's academic qualifications include a Masters of Health Science and Graduate Diploma in Health Sciences (Gerontology). She is a member of the Australian Physiotherapy Association (APA), Central Victorian Regional Group of the APA and the Gerontology Special Interest Group.

(continued)

Carol is a physiotherapist employed as an Allied Health Education and Research Manager/ Project Manager at a regional hospital in central Victoria. One of her tasks is to assist with the development of supervision policies for allied health in this organisation. For many years she worked in a multidisciplinary rural health team in this area. During the past two years she has been running two projects within the Transition Care Program. Carol has a Masters of Health Science and is a PhD candidate studying older people at the transitional phase of life when they are considering their long-term care options.

1 *Tell us about your role. What does a typical day involve?*

We work for the Transition Care Program (TCP) which is a time limited, goal focused, multidisciplinary program assisting patients to achieve maximum potential after an acute or subacute hospital admission. It provides low intensity therapies to patients with complex health issues which may include musculoskeletal, general medical, oncology, neurological, cardiopulmonary, cognitive, psychological conditions and/ or frailty. The program that we work for has 40 beds located either in a supported accommodation unit or in the community. The age criterion for TCP is 65 years but our program also has funding for an additional nine 'Restorative Care' beds for patients less than 65 years.

Our role includes:

- provision of physiotherapy services to the TCP patients which includes assessment, treatment, discharge planning, liaising with the multidisciplinary team, family, care staff and GPs
- supervision of the physiotherapy team which includes allied health assistants
- assisting with program planning, development and data collection
- supervision of students
- research and professional development activities.

A typical day includes:

- assessing new admissions
- assessing and documenting for discharges
- following up on client falls
- reviewing therapy programs
- case discussion and/or weekly case conference
- assisting with other appropriate referrals, i.e. Hospital Admission Risk Program
- representing TCP on committees
- visiting clients at home and the supported accommodation unit to provide therapy interventions
- student scheduling, orientation, monitoring and evaluation.

2 *What are some of the challenges you face as a clinical supervisor?*

The current challenges in our role as supervisor include having the appropriate patients for students to manage independently, and providing enough clinical contact time for students to experience the wide range of therapy activities such as objective and subjective assessments. It is difficult finding the increased amount of time needed for organising, orientating, supervising, monitoring and evaluating students. Providing opportunities for students to experience cultural, legal and

confidential practices in action is a challenge. A further difficulty is that students may not view complex aged care as a desirable area of work. It appears that students expect to do a functional assessment rather than using a medical scientific approach to dysfunction when treating an elderly patient in the TCP environment.

3 *What is unique about this setting in terms of student supervision?*

Unique aspects include:

- The bed based TCP places are not acute, subacute or residential care so are a different category and approach from these more common areas.
- The low intensity therapy requires high level skills in negotiation and communication with patients to establish their physiotherapy program as the patients are empowered to work towards their own goals in conjunction with their physiotherapist.
- Supervision of students in a patient's house requires acceptance from the patient. The supervisor also needs to have the ability to make themselves 'invisible'.
- Working in the community offers environmental challenges. Where supervision to ensure safety during physio program practice is necessary the physio has to be innovative to find appropriate support.
- Discharge planning requires a knowledge and understanding of what services and supports the community has available.
- Due to the time taken in travelling to visit patients in the community fewer visits can take place in one day, thus limiting the range of experiences that the student can access.

4 *What clinical skills are important for this setting?*

Skills that are necessary in this setting include:

- great observational skills
- the ability to implement outcome measures in a range of environments
- a solid understanding of the normal changes that occur with ageing
- the ability to communicate with a wide variety of people including patients, families, GPs etc.
- being able to offer an effective intervention without necessarily having access to a comprehensive medical history
- the ability to identify issues outside the scope of physiotherapy practice which may require ongoing referral
- knowledge of what services are available in the community
- clinical reasoning and an ability to prioritise contributing factors
- the ability to acquire the necessary information in the least amount of time with a minimal amount of physical testing when working with elderly frail patients
- knowledge of the wider multidisciplinary team and their roles and referral criteria.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*

Third year student requirements include:

- successful completion of the musculoskeletal core unit
- revision of neurological theory and practice

(continued)

- some knowledge of hydrotherapy
- knowledge of normal ageing.

Fourth year student requirements include:

- complete the musculoskeletal core unit
- revision of neurological theory and practice
- some knowledge of appropriate discharge options and psychological conditions and care
- knowledge of hydrotherapy, normal ageing and the multidisciplinary team.

6 *What are some of the key learning opportunities available to students?*

Learning opportunities for students doing a TCP clinical placement include:

- students are able to watch experienced therapists at work
- students are able to practise working with older patients with complex conditions
- students can see the broad multidisciplinary team in action including less common therapies such as the dentist, optometrist, podiatrist, aged persons mental health, case management services, carers support and Home and Community Care services
- students are involved in the path of care from the acute hospital to the patient's home
- facilitation of student familiarisation with what functional abilities equate to high or low residential care or people being able to go home
- opportunities to see how people with complex health and psychosocial situations can still manage in their home environment.

7 *What would you expect from a 3rd year or 4th year student on placement?*

Third year student expectations include:

- professional appearance
- willingness to learn and participate
- demonstrating initiative
- basic clinical skills
- good communication
- some time management skills.

Fourth year student expectations include:

- professional appearance
- willingness to learn and participate
- demonstrating initiative
- more advanced clinical skills and increased confidence
- good communication
- time management skills
- skills in assessment, treatment and discharge planning.

8 *What parts of the placement could students find challenging? What tips do you have for them?*

Student challenges include being:

- able to manage times when supervisors are doing administration
- able to read their supervisors' communication styles when they have a number of supervisors

- able to deal with lots of new situations every day in and out of work—new work environment, new town and accommodation, etc.
- able to work within a multidisciplinary team
- aware of their current skill level and be able to work within and to increase it
- able to manage and deal effectively with feedback from lots of people—the patients, their families, other health workers.

Tips for students:

- be prepared to do homework
- have tasks ready to access easily for downtime
- be prepared to ask questions and accept direction
- have active listening skills
- have a support system outside the clinic
- enjoy yourself!

INSTITUTIONAL SETTINGS FOR FIELDWORK PLACEMENTS WITH OLDER PEOPLE

Acute hospital wards

Older people encountered in adult orthopaedic, surgical and medical wards comprise two main groups: those who are well and admitted for elective procedures, and those who are more or less dependent and admitted with injuries or illness. They are therefore optimally well or quite unwell, which is the basis, in addition to their age and current morbidity and medical, social and behavioural history, for developing treatment goals. Thus patients must be seen and managed as individuals, where their present condition needs to be considered in the framework of their health, social and behavioural environment. In acute hospital wards, older people may be admitted to one of the following wards:

› *Orthopaedic wards*: The well elderly who present for elective surgery commonly are admitted for hip or knee joint replacement or laminectomy. Older patients who are often quite unwell and dependent are admitted for non-elective surgery, which frequently includes treatment of proximal femoral fractures after falls.

› *Surgical wards*: Patients who could be considered reasonably well might be undergoing elective surgery for cancer treatment, which could include bowel resection, lung resection, neck resections or arterial bypass surgery. Conversely, surgery might be required to correct a life-threatening situation such as bowel obstruction or rupture, ruptured aortic aneurysm or arterial embolectomy, and the patient is acutely ill.

› *Medical wards*: In most instances patients admitted to medical wards will be dependent in some aspect. Many are admitted to hospital because they need their medical conditions investigated and optimal management initiated. These patients often will be frail and fall frequently. These patients require specific ward management if they are to be safe. Other elderly patients admitted to the medical wards will have had acute cardiac events, stroke, or chest or other infections, and will be dependent.

Rehabilitation or transitional care hospital wards

In rehabilitation or transitional wards the elderly patients that you will encounter are normally still recovering from an acute illness. Although their condition has improved, they are still not sufficiently independent to return home safely. They might also be waiting for home modifications to be undertaken to enable them to function at home, so there is no other option but to stay in hospital. Others will be waiting for nursing home bed availability.

Palliative care wards

Some patients will be admitted at the end of life, when they can no longer be managed at home, and hospice accommodation is not an available option. You might also participate in a fieldwork placement in a hospice where all inpatients will be receiving palliative care. The focus in these experiences is not curative but palliative. In palliative care, minimising the experience of symptoms is the primary issue in treatment, especially prevention of undesirable complications, such as pressure ulcers caused by difficulty in moving. Enabling the best quality of life during a patient's final days is the main aim of palliative care.

THINK AND LINK

Chapter 13 is about palliative care and the issues that you, as a health professional, need to be aware of when working in this area of care.

DISCHARGE PLANNING OCCURS AT ADMISSION

A number of similar aspects relating to two cases are presented in the case study below. Each woman is having elective right hip replacement surgery, lives in the community, is cognitively capable and should expect to return to her previous situation on discharge from hospital.

CASE STUDY

Comparison of management for elective hip replacement surgery between a well and a frail elderly person

PATIENT 1

Anna Arthritis, 68 years old, has been admitted to the orthopaedic ward for right total hip replacement surgery tomorrow. She has a long history of osteoarthritis, and the pain in her right hip has persuaded her to have surgery so that she can get back to unrestricted participation in family, leisure and part-time work activities. She has no additional medical conditions, has never fallen, lives independently in her own highset home with her husband, who is well.

PATIENT 2

Flora Falls, 84 years old, has been admitted to the orthopaedic ward via the hospital Accident and Emergency Department. She was brought there by ambulance after being

found on the floor of her bedroom by the person delivering Meals on Wheels to her home. Mrs Falls lives alone in a lowset home. In addition to receiving community assistance from Meals on Wheels three days per week she also has home help come in once a week to assist with house cleaning. Her niece, who takes her shopping weekly, is her only relative living locally. Mrs Falls has controlled left ventricular failure and hypertension, diet-controlled type 2 diabetes and osteoporosis. She has a BMI of 20, and very good vision since her cataract operation last year.

Mrs Falls had fallen returning from the bathroom sometime during the night before she was found. This meant she has been lying on the floor for about 10 hours and was quite confused due to hypothermia and hypoglycaemia, and shock as a result of these conditions and her fractured right hip, which was confirmed in hospital. The planned management of her hip fracture was to surgically replace the femoral head tomorrow after her medical state has become stable.

What might confound the expected outcome of returning home, especially for Mrs Falls, is a preconceived expectation of failure to achieve independence in activities of daily living. This attitude might be fuelled by her confused state on admission, which was a result of her hip trauma and inability to move. Her age of 84 years might also confound the appropriate diagnosis of delirium with a misdiagnosis of dementia, which, when written in a patient's record, changes the approach of health professionals to planning discharge because of the expectation of dependency. In some instances, access to appropriate rehabilitation might also be denied by a diagnosis of dementia, so all health professionals working with Mrs Falls should realise their responsibility to ensure equity of access to services.

Ageism should not contribute to any disparity between the post-operative rehabilitation of Anna Arthritis and Flora Falls, since both were successful community dwellers before hospital admission. Having said this, a study by Ubachs-Moust and colleagues (2008) has shown that the patient's age has an impact on every phase of decision-making, and is a factor in every component of the clinical reasoning process when clinical cases involving octogenarians were evaluated. Ubachs-Moust and colleagues suggest that, ethically, age should not predominate when the clinical pathway for each patient is determined by the team and each team member should question decisions made from an ageist perspective rather than from the clinical evidence.

The approach taken when planning the discharge of these women should include the patient's desires and needs with consideration to physical, spiritual, social and behavioural aspects, such as:

- the patient's current living situation and how supportive and successful this was before the event
- the family support and support from other parties
- the patient's financial situation and ability to pay should additional assistance be required on discharge.

Mrs Falls might have a slower path to recovery because of her pre-admission complications caused by the circumstances of her fracture. This might require her to undertake inpatient rehabilitation for a few days longer than the usual five to seven days required post total hip replacement, such as that in the case of Anna Arthritis.

REFLECTION

POST-OPERATIVE MANAGEMENT OF MRS ARTHRITIS AND MRS FALLS

1 Should the usual post-operative management of the patient after this type of surgery be modified from the 'procedures manual directions' to accommodate for the individual differences encountered in each woman?
2 What prevention interventions need to be instituted to prevent complications related to the surgery or age so that the planned outcome eventuates? Examples of prevention interventions might include prevention of pressure areas and further falls.

COMMUNITY GERIATRIC FIELDWORK PLACEMENTS

Fieldwork placement in the community encompasses the management of clients in their place of residence (see the case study below). This will include home visiting to the client's private residence, as well as residential aged care, including hostel (low-care) and nursing home (high-care) residence.

CASE STUDY

Comparison between two frail older persons who both have complex and chronic conditions

CLIENT 1 (LIVES IN COMMUNITY)

Miss Heart lives alone in a retirement village. She has controlled left ventricular failure, chronic obstructive pulmonary disease (COPD), chronic low back pain and urinary stress incontinence. She manages without any home services, but has a very poor exercise tolerance and most activity leaves her short of breath. Cognitively she has no problems.

CLIENT 2 (LOW-CARE RESIDENTIAL AGED CARE)

Mr Chester lives in a hostel (low-care residential aged care facility). He has COPD, controlled hypertension, painful osteoarthritic knees, urinary urge incontinence since prostate surgery three years ago and early-stage dementia.

CLIENTS' GOALS DIRECT CARE

Neither of these clients requires acute medical or health professional care at present. Each would, however, benefit from pre-emptive intervention to maximise his or her current functional ability for easier participation in lifestyle activities. Both these clients' goals are to remain in their current living situation for as long as possible and with optimal quality of life. Health professionals work with these clients to empower them to achieve this goal. This might be in various ways, and through provision of specific treatments or advice, but of most importance is the development of self-management ability by the clients. One way to achieve this would be to enable these clients to participate in a **chronic condition self-management (CCSM) program** run by community-based teams specifically trained

to deliver this education program. As part of your training and as part of your fieldwork placement you might participate in a program such as this, either as leader or observer. The CCSM program teaches participants how to better manage their chronic medical conditions, helps them make informed decisions regarding their health and reduces the reliance on direct healthcare until needed. This type of program addresses preventative health and health promotion issues, and your role as a health professional might be to provide information to the client regarding where to access physical activity programs or social programs in the community.

Optimal treatment outcomes

Optimal treatment outcomes will be variable, and depend on the individual elder person. In all instances a clinical reasoning approach to management should be used. Basic requirements for this reasoning process include:

- a comprehensive understanding of the patient's ageing process and morbidities
- an assessment that considers all aspects of the individual as well as the physical and social environment he or she lives in
- identification of primary problems:
- all potential confounders to treatment efficacy, contraindications or special precautions that need to be taken
- secondary problems of lesser importance for the patient
- short-term goal-setting that is determined in conjunction with the patient and agreed upon by all involved parties
- use of suitable outcome measures that will enable change in patient status to be tracked and for informed decision making to be made regarding satisfactory progress or need for a change in intervention strategies or referral to another specialist practitioner such as a physiotherapist or podiatrist for example.

REFLECTION

THE INDIVIDUAL OLDER PERSON

It is very easy to be overwhelmed by the complexities of patients' medical or surgical diagnoses and to lose sight of the elderly patient as a person. Think about why it is important to find out about the social, behavioural and spiritual aspects of your patient. To assist in understanding how these aspects might shape your decision-making ask yourself the question: 'If this were my grandparent, how would I approach this patient's management?' This is how you should approach all clinical encounters.

EXPECTED COMPETENCIES

On completion of a fieldwork placement working with older people, a first year student should have gained an understanding of and demonstrated their ability to follow ethical

practice in regard to communication, and working in a team under direction from an experienced practitioner. A final year student should demonstrate ability to independently implement all aspects of assessment, clinical reasoning and treatment as a member of the multidisciplinary team managing the patient while recognising where consultation with mentors might enhance outcomes and seeking out this help when indicated.

SUMMARY

Older patients will be encountered in institutions and the community. Every elderly patient or client is an individual and must be considered as such. Most older people will present with multiple comorbidities that will need to be assessed for how these will impact on mobility and function and any chosen interventions. Assessment and treatment will be determined by the medical status of the individual elder, their social situation of living, their behaviour and their expectations. In addition to managing the presenting problems, holistic management should include pre-emptive preventive intervention to enable optimal quality of life to be attained or maintained.

Discussion questions

1 Think about the cases provided earlier. Identify specific assessment, problem identification and clinical reasoning processes and possible treatment interventions that might be indicated for your profession-specific team contribution to the patient's management. Jot this information down, as well as your rationale for the decisions you have made. Discuss your thoughts with your fieldwork educator. You might find this very useful in developing your professional skills for the field of practice (institutional or community).

2 On completion of the fieldwork placement, you need to reflect back on your expectations and activities undertaken. Did this work-integrated learning experience eventuate as you expected? Did it mirror your life experiences with older people you have encountered in everyday life away from study? How and why was it different?

3 If you have been lucky enough to do a fieldwork placement working with the older person in year 1 or 2 of your program, how might you use the lessons learnt and clinical skills attained to enhance your performance in all aspects of practice, including subsequent placements or when a graduate health professional?

Portfolio development exercise: Preventive interventions

In 400 words identify why and how incorporation of preventive interventions pertinent to your patients' management would have enhanced or did enhance your patient's outcomes and so best practice in your fieldwork experience.

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CHAPTER 19

Working in Mental Health

Geneviève Pépin

LEARNING OUTCOMES

After reading this chapter you should be able to:

- define mental health
- reflect on individual perception of mental health and mental illnesses
- discuss challenges in mental health practice
- develop strategies to be better prepared to enter the mental health workforce.

KEY TERMS

Mental health
Stigma
Stress
Teamwork

INTRODUCTION

Working in a **mental health** setting can be challenging, confronting, surprising and rewarding. As you start a placement or a new position in a mental health setting, you might be confronted with stigma and discrimination. You might have your own opinions and beliefs about mental health-related issues, and you can be influenced by the opinions and beliefs of others. Also, your profession will have helped you develop specific knowledge, skills and attitudes for mental health practice and mental health-related issues. But how prepared are you to deal with the reactions and behaviours of clients, family members and the wider community? How prepared are you to be part of a mental health team? How comfortable are you with overlapping of roles, tasks and responsibilities?

There have been numerous changes and reforms in mental health services and delivery, most often seeing an increase in community-based services. As service structures and intervention strategies are changing and evolving so are the roles and functions of mental health professionals. Social workers, occupational therapists, psychologists, nurses and psychiatrists work alongside each other and this could be an opportunity to broaden your knowledge base and consolidate your professional identity and ultimately your place within the mental health team (Godin 2010).

This chapter will address mental health practice from an interdisciplinary perspective. Various aspects of mental health practice will be presented and discussed. Remember, however, that each health profession has theoretical frameworks, and specific tools and strategies to provide services to a person with a mental health condition. You will be encouraged to integrate your discipline-specific knowledge and be curious about that of your colleagues from different health backgrounds. Aspects of mental health practice that can be challenging will be identified and strategies to cope with these challenges will be suggested. Throughout the chapter, you will also be encouraged to reflect on your own beliefs and attitudes towards mental health and mental illnesses.

WHAT IS MENTAL HEALTH?

First, it is important to define 'mental health'. However, defining 'mental health' can be problematic, as it may be understood differently by different groups of people and in a wide range of contexts (Blair et al. 2007). What someone from West Africa considers as an appropriate definition of 'mental health' may very well differ from what someone in Eastern Europe would say. Your understanding and definition of mental health can differ from that of a friend or a family member. Godin (2010: 43) highlights that mental health professionals have their own 'psychiatric ideologies (beliefs about what causes mental illness and how it should be treated)'. This implies that the concept of mental health varies according to cultural, personal and socio-contextual factors. As a result, mental health professionals might align interventions with their psychiatric ideologies, and the community in which a person lives may be welcoming and ready to support someone with a mental health issue or it may alienate and isolate that person.

REFLECTION

WHAT IS MENTAL HEALTH?

1 Reflecting on your personal experiences, training and professional expertise, develop and write down your own definition of mental health. What would be the important components of your definition of mental health?
2 When you have developed your own definition of mental health, ask three people (friends or family members) to come up with their own definition and compare theirs to yours.
3 What are the similarities and the differences?

The World Health Organization (WHO) defines 'mental health' as 'a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO 2007). In the view of the WHO, mental health is not limited to the absence of a mental disorder and is related to 'the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders'. Other authors have described mental health as 'the successful performance of mental functions, in terms of thought, mood and behaviour that results in productive activities, fulfilling relationships with others, and the ability to adapt to change and to cope with adversity' (Sadock & Sadock 2007: 12). Headspace (2012), the National Youth Mental Health Foundation, proposes the following definition of mental health: 'Mental health is about being able to work and study to your full potential, cope with day-to-day life stresses, be involved in your community, and live your life in a free and satisfying way'. Finally, the Scottish Public Mental Health Alliance (SPMHA 2002) has developed the concept of positive mental health. It identified attributes such as the ability to (1) communicate and do things; (2) express oneself; (3) develop a sense of autonomy; and (4) form and maintain relationships with others. These attributes are believed to provide the base for positive mental health and promote wellbeing (SPMHA 2002). Although this definition is older, the concept of positive mental health and the different attributes the SPMHA put forward are still current.

These definitions highlight some very interesting concepts such as wellbeing, adaptation and ability to cope, participation, engaging in fulfilling relationships, communication, self-expression and autonomy—all of which relate to the health professions.

STIGMA, LABELS, MYTHS AND MENTAL HEALTH

Movies such as *One Flew Over the Cuckoo's Nest* (1975) depict a brutal view of mental illness and related interventions. Realistically, not all individuals with a mental illness behave like the characters portrayed in some movies and television series. Sometimes what you see in movies is very close to reality, but much more needs to be known to fully understand mental health and mental illnesses. In the meantime, incorrect information and misconceptions are common in society. It is important to recognise that we, as mental health professionals, are not above such misconceptions and might have our own beliefs or apprehension towards mental illnesses and persons with mental health problems.

The *Australian Oxford Dictionary* defines '**stigma**' as 'a mark or sign of disgrace or discredit' (Moore 2004: 1269). The National Mental Health Consumer & Carer Forum (2010) defined stigma as being 'the process of labelling or stereotyping people in negative or derogatory terms and images'. People with a mental illness are repeatedly misrepresented in the media, and prejudicial representation of mental illness leads to stigma and discrimination, culminating in social isolation for consumers and adversely affecting the morale of carers and jeopardising the support they provide. Stigma labels a person as not being 'normal', not 'fitting' in the broader community (Department of Veterans Affairs [DVA] 2008a). Stigmata often arise from myths about mental health and people with a mental health condition, and contribute to portraying a negative image of these persons. Our own beliefs can contribute to maintaining stigmata about mental health.

You might have personal beliefs or have heard incorrect information and myths about mental health and mental illnesses. You may also have specific opinions about the settings in which a mental health professional works or about the behaviours or appearance of individuals with a mental health condition. Myths can arise from a variety of sources. They can be the result of a lack of understanding about a particular situation, incomplete knowledge or incorrect information, or they may be the result of a fear or unpleasant past experience. What is important here is to acknowledge that we all have personal beliefs and opinions about mental health and mental illness. Reflecting on those, acknowledging that they are part of who we are, but also identifying their sources and learning to limit the impacts of your myths and misconceptions will help you in becoming responsible and accountable for your own mental health practice.

REFLECTION

IDENTIFYING YOUR MYTHS

Consider some of the following myths:

- Persons with a mental health problem are violent and dangerous (DVA 2008b; Government of Western Australia Mental Health Commission [GWAMHC] 2010).
- Mental health problems are caused by personal weakness (DVA 2008b; GWAMHC 2010).
- Mental health problems are hereditary (DVA 2008b).
- A person with a mental health problem should be kept in hospital (GWAMHC 2010).
- A person with a mental health problem will never get better (DVA 2008b).
- A person with a mental health problem can 'pull themselves out of it' (GWAMHC 2010).

What do you think about these myths?

Think about your personal views about mental health and mental health-related conditions. What are your myths?

KNOWING YOURSELF

Before starting your fieldwork in a mental health setting, it is important to take the time to reflect on yourself and your perception of mental health. You probably have hopes and desires to reach specific goals during your fieldwork experience. You may strive to increase your knowledge and skills in mental health practice and grow as a health professional and you most probably want to pass this fieldwork placement.

During your fieldwork placement in a mental health setting you may see clients with acute symptom manifestations and severe mental illnesses. You may meet family members and carers who are scared, don't understand and are seeking answers. You may also work with clients who look perfectly 'normal' to you, and you may not understand why they are receiving service from your organisation. You may meet clients who are eager to recover and will engage in their recovery process easily, although other clients may challenge and resist you or even refuse interventions.

It is important for you to address your personal beliefs, views and concerns about mental health and mental health-related conditions. Knowing yourself, identifying your strengths and areas to improve will help you identify who to talk to, the training or information you should obtain and where to get it. It will help you deal with fears or concerns and will assist you in your learning experience. Sladyk (2002) has developed some tools to help students know themselves better. One of these tools is based on a list of fears expressed by students. The following Reflection is an adapted version of this list. Look at some of these fears and add your own concerns.

REFLECTION

KNOWING YOURSELF

I will be stressed, uncomfortable or scared if I ...

- see an aggressive client
- see someone who looks really strange
- find myself alone with clients
- have to find something to say to clients
- say something wrong and get the client upset, aggressive or sicker
- see someone I know
- have to comfort parents
- have to interact with individuals whose values are different from mine.

What about you? What are your concerns?

Reflecting honestly on your thoughts about mental health and identifying areas of concern is important. You are encouraged to discuss these fears or concerns with your fieldwork supervisor and fellow students. Together, think about strategies to deal with these concerns to make the best of your fieldwork experience.

THINK AND LINK

A proactive plan to prevent problems on fieldwork can result in a surprising amount of enjoyment of a fieldwork placement. It can also help you face potential problems that could have otherwise led to failure. Chapter 9 discusses learning from failure on a fieldwork placement. Chapter 3 also discusses reflective practice and will be helpful to you here.

MENTAL HEALTH PRACTICE: LET'S CONSIDER A FEW THINGS

The setting

Mental health practitioners can work in very different settings. Some work in a more traditional context, such as a psychiatric hospital or a psychiatric ward, interacting with clients presenting acute symptoms of a wide variety of mental illnesses.

Other practitioners, who work in outpatient settings, will support clients in their journey to recovery from the hospital to their home and community. They will work with clients who probably won't present acute manifestations of their mental health-related condition. There will be residual symptoms, and the impact on the person's level of functioning will vary greatly. Your interventions may be orientated towards housing and community living skills.

You can also find mental health professionals in community settings, not-for-profit organisations, mental health associations or private practice. Again, clients receiving services in any of these settings will have different needs, and present with a wide variety of mental health-related issues. As a result, practitioners may focus their interventions on symptom reduction, using specific approaches and interventions, or they may address issues related to return to work and vocational rehabilitation or psychosocial rehabilitation. Remember that these are just a few examples of mental health settings. Depending on the region, state or country where you live and work, the focus of your interventions, your tasks and responsibilities may vary greatly. Knowing about the setting where you will be doing a placement will help you understand what is expected of you and what you can expect from the placement.

For example, the *Fourth National Mental Health Plan–An Agenda for Collaborative Government Action in Mental Health 2009–2014* (Commonwealth of Australia 2009) has identified the need for the mental health workforce to be culturally competent, to recognise the challenges faced by rural and remote communities and their different priorities, and for services to be innovative and support the needs of the persons with mental health problems, their families and their community. Furthermore, mental health services must support continuity and coordination of care, avoid duplication, and be accessible and flexible. This can only be achieved through collaboration between mental health professionals, consumers, their family, their community and services.

This means that, on the one hand, your role and functions as well as those of your mental health professional colleagues might be very clearly defined or, on the other hand, that they are not discipline specific and that several functions might be shared between you and your colleagues. In the views of Stickley and Basset (2008: 571), mental health practice will continue to be 'more community minded than medically minded' and should promote recovery, consider the person in their context and consider broader social issues.

Teamwork and role blurring

In a context where mental health practice can take so many different forms the importance of working as a team goes without question, but role blurring is an issue that should be considered (Lloyd et al. 2005). When you start your fieldwork placement you will probably join a team. In this team, each person plays a role and performs certain tasks. Some disciplines share knowledge, skills and approaches to mental health interventions. Some of us deal with grey areas between disciplines better than others. Sometimes, however, we can be concerned about invading our colleagues' space or losing our core roles or knowledge to other professionals.

When thinking about *teamwork*, ask yourself the following questions:

- How specific is each role?
- Which tasks are common to more than one member of the team, and which ones are discipline specific?

- How easy is it to identify, understand and deal with each other's role?
- How do you understand your role as part of a mental health team?
- How comfortable are you with the boundaries that define your role?
- How comfortable are you with a possible blurring of the roles among the team members?

These are important questions to consider as they will help you build and consolidate your professional identity. They will also facilitate constructive working relationships.

SUPERVISOR PROFILE

DANIELLE HITCH

Danielle is a consultant occupational therapist and lecturer/fieldwork educator at Deakin University. She has worked in mental health settings for over a decade in both Australia and the UK. Danielle is currently completing a PhD in occupational therapy for mental health. Her special areas of interest are the integration of theory/research/action and supporting clinicians to make best use of evidence. Danielle has also developed expertise in working with people who have complex needs (particularly those with dual diagnosis or co-occurring physical disabilities) and those from low socio-economic backgrounds.

1 *Tell us about your role. What does a typical day involve?*
I have worked in almost every field in mental health—acute, community, specialist services, triage and private practice. My roles in each setting did vary, but much of the time my job title was case manager. I have worked with clients of all ages, who were experiencing mental health problems. There was a great deal of autonomy and variety in my work, and no typical day.

2 *What are some of the challenges you face as a clinical supervisor?*
Given the level of autonomy in my role, I was often solely responsible for student education and supervision. This can be very challenging, as you want to provide your students with the best possible experience while also maintaining your clinical caseload and team duties.

3 *What is unique about this setting in terms of student supervision?*
In mental health settings, students can be exposed to situations and risks which no previous life experience or education can prepare them for. The work also takes place in mostly non-clinical settings—embedded within the community. It can be a life-changing experience, so an educator is involved in both the student's personal and professional development.

4 *What clinical skills are important for this setting?*
Excellent interpersonal skills are crucial in mental health, along with a sound knowledge of all the other services which your clients could access in the local area. Documentation is also important (particularly when dealing with emergency services and the court system), and a capacity to approach your practice in a flexible and pragmatic way. The ability to make the most of limited resources is also an advantage.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*

- First year student: General understanding of the different type of mental health problems.
- Second year student: Basic familiarity with forms of assessments (particularly the mental state examination) and treatment.
- Third year student: Developing an understanding of the lived experience and functional impacts of mental health problems.
- Fourth year student: Familiarity with the mental health system (both statutory and non-government), including different types of services and how they interact with each other.

Along with traditional textbooks and research, there are a number of great online resources on these topics, such as the Alzheimer's Australia (www.fightdementia.org.au) and beyondblue (www.beyondblue.org.au) websites.

6 *What will students learn by completing a placement in this setting?*

Learning can happen at any time in this setting. Students should approach a mental health placement with an open mind, and not wait for formalised supervision or report sessions for feedback. Skills which can be developed include interpersonal/interviewing skills, clinical reasoning, use of standardised and non-standardised assessments, collaborative goal setting and client centred treatment.

7 *What would you expect from a student on placement?*

- First year student: Observation of clinician, with the ability to comment on these events with some perception. Ability to hold a general conversation with a client.
- Second year student: Able to gather some basic information from clients to support assessment. Co-facilitating sections of a group program.
- Third year student: Autonomously undertaking individual assessments, and reporting mental state as a standard part of client contact. Running groups with a co-facilitator. Managing a small caseload under regular supervision.
- Fourth year student: Autonomously acting in this setting, working with a full caseload of standard clients and/or running groups. Working with the supervisor collaboratively with more complex or challenging clients. Managing own time and caseload.

8 *What parts of the placement could students find challenging? What tips do you have for them?*

Mental health is a wonderful setting, but can also be a little disorienting and unsettling at times. You may come across situations and stories which provoke strong feelings. Be willing to 'go with the flow', and know that your best-laid plans can go out the window at any time. Use your supervisor as a sounding board, and discuss your responses (both good and bad) honestly and freely.

SUPERVISOR PROFILE

NICOLA KATHERINE

Nicola is a hospital-trained psychiatric nurse from Christchurch, New Zealand who has worked in diverse clinical settings. She completed her Bachelor of Nursing and Bachelor of Education in Melbourne and has been involved in education for the last nine years. She is a Credentialed Mental Health Nurse who is committed to working in the mental health field.

1 *Tell us about your role. What does a typical day involve?*
My role is as a mental health educator in the private sector in which I am responsible for facilitating undergraduate and graduate nurses. This involves organising an education program that is in line with the education providers and national competencies to ensure clinical objectives are met. I work alongside the student to model, coach and assess the student's functioning with patients who experience illnesses ranging from depression, anxiety, psychotic disorders, alcohol and other drugs and personality disturbances.

2 *What are some of the challenges you face as a clinical supervisor?*
The challenges faced in this role involve negotiating a smooth transition into clinical work in a setting where interpersonal relationships are very important and often difficult to apply in practice. More is required of the student to engage with this patient group in order to develop a subtle and complex skill set which is in contrast to the task-oriented work they are used to. The nature of working with mental health patients raises anxieties for many students which can be a confronting experience for them.

3 *What is unique about this setting in terms of student supervision?*
The setting provides a unique opportunity for students to grow as human beings and develop clinical expertise with the right balance of hands-on supervision and independent management of a caseload. The student is required to perform a supervised mental state examination and interview assessment which will help them develop skills in this area.

4 *What clinical skills are important for this setting?*
Interpersonal skills and a nurse's ability to engage and relate with people is crucial in this setting. Integrated with accurate assessment skills and the application of critical thinking skills to ascertain and deliver person centred care, this is a powerful aid to assist in the recovery of patients.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*
Students preparing for their mental health placement need to be familiar with how to conduct a mental state examination and have knowledge of the basics of interviewing skills. They need to have an understanding of the clinical manifestations of major mental health disturbances, which are outlined in their chosen text books. Just as important, the student needs to prepare their attitude to get beyond the myths surrounding mental health so they can get the most out of their experience.

6 *What are some of the key learning opportunities available to students?*
Students will be given many opportunities to develop their interpersonal skills in a structured manner. They will learn the role and function of a mental health nurse and be involved in all aspects of care delivery, e.g. administer psychotropic medications, participate in the procedure of electroconvulsive therapy, attend outreach home visits, develop clinical documentation skills and handover skills, and also be able to observe psychotherapeutic groups which are facilitated by psychologists.

7 *What would you expect from a student on placement?*
I expect students to engage with the mental health patients in their placement and thus be able to change the preconceived ideas and stigmas associated with this area of nursing. I expect the student to embrace their learning opportunities to make themselves more able to nurse and communicate effectively with these patients in whatever clinical environment they are in.

8 *What parts of the placement could students find challenging? What tips do you have for them?*
Students commonly have fears about being in a mental health environment which can often provoke personal difficulties and be challenging to deal with. This can be evident in students withdrawing from patients, identifying too much with them, or approaching the patient from a one-dimensional perspective to dispense advice and try to 'fix' a person. It is often challenging for a student to adjust from a 'doing' mode into a 'being' mode and to come to grips with the use of self as a therapeutic tool.

I expect students to be able to be engaged with their clinical experience and their professional functioning, to be open to guidance in the process of their learning and to be a proactive participant in the unfolding of their skills.

The following Reflection is about helping you reflect on your discipline and practice as a team member.

REFLECTION

ME AS PART OF A TEAM

Table 19.1: Me as part of a team

Think about your practice as a member of a mental health team. Reflect on your training and think about what you have learnt about your profession. What distinguishes you from other members of the mental health team?
Answers:

CASE STUDY

Alfie

Alfie is a 39-year-old IT technician in a secondary school. He has been married for 15 years. His wife is a stay-at-home mother who takes care of their four children. Recent budget cuts and restructure in the education system have meant that now Alfie needs to travel between three different schools. He has been feeling anxious and has had trouble sleeping for the last four to five weeks. Originally, he seemed a bit depressed and tired, but over the past few weeks his mood has changed. He is very enthusiastic about his work, has several major IT projects for the different schools, and even plans a trip overseas to promote his projects to other schools. He can get a bit aggressive when his wife tells him that his plans are not realistic, and that he might have to tone down his ambitions a bit. He has been spending money irresponsibly, and Alfie's wife is seriously concerned about his behaviour.

Recently, Alfie has bought a brand-new and very expensive car with every possible gadget. One afternoon, he picked up his children from school and took them for a ride to test the new car. He was arrested on the freeway after being chased by the police as he was changing lanes trying to avoid them. Alfie was driving 50 kilometres over the speed limit. When the police finally stopped him, he was disorganised, overexcited and irrational. He told them he had been hired by a major car company to test the new IT technology on their latest cars.

The police officers contacted Alfie's wife, and they took him to the nearest hospital. Alfie was admitted to the psychiatric ward after a bipolar disorder was diagnosed at the emergency department by the consultant psychiatrist. Alfie wants to leave the hospital and go back to work and to his family. He says he values his work and that his role as a father means everything to him. Alfie's employer is concerned about his capacity to return to work and his wife is afraid he will put the children's lives and his own in danger again. She is also concerned about loss of income. She struggles to make sense of what has happened and to reassure her children.

You are part of the mental health team. The team is made up of: 1) a psychiatrist, 2) a nurse, 3) an occupational therapist, 4) a social worker and 5) a psychologist. Here are a few concerns the team members have identified.

Your first task is to match each concern with one or more members of the team and to provide one justification for each choice and one intervention this professional would implement.

Concerns	Team member(s) and justification	Intervention
Return to work		
Medication management		
Living arrangement		
Family interactions		
Role as a father and a husband		

(continued)

Concerns	Team member(s) and justification	Intervention
Cognitive skills		
Expression and management of emotions		
Meaningful activities		
Parental capacity		
Social interactions		
Others:		

Once you have completed the above table, compare your results with other health students or professionals. Discuss your choices and justifications and decide if any adjustment should be made.

Feel free to add ideas about any other areas of Alfie's level of function and match them to ideas presented by other members of the team.

QUESTIONS

1 How difficult did you find this exercise?

2 How well did you know the different roles of the team members?

3 Was there role blurring?

4 How can you maintain your specificity and be part of a team?

Knowing and understanding each other's roles and responsibilities within the team is important because it decreases professional self-doubt, limits conflicts and adherence to a uni-professional culture, promotes continuity of care and of services and increases job satisfaction (Peck & Norman 1999; Lloyd et al. 2005). Furthermore, as we have discussed previously, to be effective and address the needs of consumers, their families and their community, contemporary mental health services require teamwork, collaboration and constructive working partnerships.

Stress

Stress experienced by health professionals in relation to mental health practice has been discussed in the literature for several years (Peck & Norman 1999; Lloyd et al. 2005). The main causes of stress reported by health professionals working in mental health settings are workload, poor job satisfaction, lack of skilled staff, and inadequate training and supervision (Lloyd et al. 2005).

These findings are very helpful, as they provide you with guidelines to become a better mental health professional. Increasing your skills and knowledge about mental health conditions and clinical manifestations of different psychological and psychiatric disorders will help you build and consolidate your knowledge and skills. *The Diagnostic and Statistical Manual of Mental Disorders*, which is now available in a revised version (American Psychiatric Association 2002), with the fifth edition to be published in May 2013, covers

mental illnesses in detail. It is widely used throughout the different health professions. There are other textbooks that you will have used in your own course that can provide you with information about mental health conditions and link it more specifically to your discipline. There are several books and papers on therapeutic relationships, client-centred practice and interviewing techniques and skills that will help you build your skills and consolidate your knowledge. These resources may be generic, or profession specific. Also, revisiting the intervention process related to your profession will give you a structure to develop your intervention plan.

REFLECTION

Who are the main authors in your discipline and whose work will help you increase your knowledge and skills? What are their mains findings? What do you find helpful?

Clinical reasoning is another powerful tool for you to use. Using clinical reasoning when making decisions about and with a client will contribute to the implementation of a thorough intervention plan. It will enable you to justify your decisions and interventions. Clinical reasoning brings theory and practice together. It helps you make a decision based on evidence (Higgs & Jones 2000). Developing a reflective practice will also facilitate your understanding of what is happening in the context of your work with your client/clients. Being reflective makes us aware of what we are doing, why we are doing it and critically reflect on the effectiveness of our actions to adapt or change these actions and mostly understand why they need to be changed (Taylor 2010). Being reflective helps us avoid repeating mistakes, and getting frustrated with our practice.

As a health student you will be supervised by an experienced mental health professional. Although these persons' roles, functions and titles may vary according to each profession, they are there to help you through your fieldwork placement (Healey & Spencer 2008). By making the most of the relationship you have with your fieldwork educator, you can maximise your fieldwork supervision with her or him by setting goals, revisiting these goals and discussing your perceptions and the challenges you are facing. Other examples of supervision activities are brainstorming to identify intervention strategies, then justifying your decisions.

Finally, self-care when working in a mental health setting is important. You have to think about your own wellbeing and engage in activities, outside work, that are important and meaningful to you. You need to have a place to let go, moments that are your own and that will contribute to maintaining a healthy life and work balance.

SUMMARY

This chapter aimed at exploring the field of mental health. The very nature of mental health and mental illnesses may contribute to some of the feelings and perceptions individuals have towards them. Stigma and myths about mental health are common among members of the general public, and we are all exposed to them. It is important to take time to acknowledge individual concerns and perceptions, as you are getting ready to start a placement in mental health.

Reflecting on your own perceptions and beliefs about mental health helps you to face any resistance you might have to undertaking the placement. Discussing these beliefs with your fieldwork educator or with other health students that are in a similar situation can help you identify strategies and actions. This chapter was also aimed at identifying strategies and actions to prepare you for some of the challenges reported in the literature about mental health. However, remember that specific theoretical foundations, intervention procedures and other aspects of your work in mental health will be influenced by your professional background and training. This chapter was meant as an introduction to mental health practice and aimed at demystifying the possible concerns or fears you might have towards this field of healthcare services.

Discussion questions

1 Reflect on a past or current situation where you felt particularly stressed, sad or anxious. How did your emotions have an impact on your daily life? How did you deal with the situation? What sort of support did you get?

2 Think about a person with a mental health issue that you might have met or worked with in a fieldwork placement. What were your first thoughts and reactions? Have they evolved? In what way?

3 What are the aspects of mental health practice, services and resources that affect you the most? What surprises you? What makes you feel uncomfortable? What should change? How can you, as an individual and as a mental health professional, contribute to these changes?

Portfolio development exercise: My proactive plan

One way to make the most of your mental health placement is to develop a proactive plan. Sladyk (2002: 49) defines proactive plan as 'a way to prevent problems on fieldwork. It begins with a positive attitude about fieldwork and your approach to learning'. This plan aims to identify your strengths and areas for improvement and come up with strategies to address these areas. The implementation of your plan also rests upon your ability to discuss issues and strategies with your fieldwork educator.

Completing your proactive plan will help you consolidate your competencies as a mental health practitioner. It will help you build your professional identity as a mental health practitioner and become responsible and accountable for your own mental health practice.

These questions will help you develop your proactive plan:

Table 19.2: My proactive plan

What are my skills and knowledge? *Determine your strengths with regards to mental health practice.*	In which areas are there room for improvement? *Identify your limits with regards to mental health practice.*	What will I do? How will I do it? *Identify actions/ strategies to maintain your strengths and address your limits.*	When will I do it? *Identify a timeframe for completion of your actions/strategies.*

This plan can be developed on your own but you would also gain from completing it in collaboration with your fieldwork educator. It could also be an interesting exercise to do with students or colleagues from other disciplines. When writing up your plan, keep the following questions in mind (Sladyk 2002):

- In which areas of your profession's theoretical foundations are you comfortable?
- Which type of assessments and interventions are you familiar with?
- What feedback did you get from previous fieldwork, and how can it be useful in a mental health setting?
- How would you rate your skills and knowledge about interaction and communication skills?

Once you completed your proactive plan, keep it in a place where it will be easily accessible and revisit it regularly to verify how the implementation of your plan is going, if you have reached your goals and if it is time to identify new goals and strategies. Your plan should be organic and change with you, as you evolve and change as a mental health professional.

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USEFUL WEBSITES

Alzheimer's Australia: www.fightdementia.org.au

beyondblue: www.beyondblue.org.au

CHAPTER 20

Working in Workplace Practice

Lynne Adamson and Michelle Day

LEARNING OUTCOMES

After reading this chapter you should be able to:

- provide an overview of areas of workplace practice for health professionals
- describe the aims and processes of occupational and workplace rehabilitation
- locate resources and references to enable further information gathering
- discuss the behaviour expected of students on fieldwork placements in workplace practice
- reflect on how to approach a particular problem in workplace practice.

KEY TERMS

Injured worker
Negotiation
Occupational rehabilitation
Rehabilitation provider
Return-to-work plan
Workplace practice
Workplace rehabilitation

INTRODUCTION

This chapter begins with an explanation of what workplace practice is and some of the processes students might expect to observe in this setting. Health professionals are employed in a wide variety of areas within the healthcare sector, including rehabilitation consultants, injury management advisers and rehabilitation coordinators, or clinicians, such as occupational therapists, physiotherapists, psychologists, podiatrists or social workers.

In this chapter, '**workplace practice**' or '**occupational rehabilitation**' refers to workplace-based or work-related services to employers, insurers and other stakeholders. It also refers to services provided to an individual seeking employment or currently working. The terms 'occupational' and 'workplace' rehabilitation are used interchangeably.

Areas of employment for health professionals in workplace practice include but are not limited to the following:

- **rehabilitation providers**, private and public
- insurance companies
- private practice
- training organisations
- government authorities, such as state and federal workers' compensation authorities and occupational health and safety bodies
- hospitals and community health centres.

Health professionals employed in workplace practice areas provide a wide range of services, such as health treatment and examinations, educational programs and consulting. Health treatment services include, for example, counselling, physical manipulation and treatment, exercise, massage services to **injured workers**, immunisation programs or pre-employment medical examinations. Other services include the management of occupational health and safety within the company or return-to-work programs offered to injured workers.

Health professionals may consult to industry on a range of issues, including developing policies and procedures to improve health and safety of employees, advising on change management strategies and being involved in mediation services. Educational services include training to employers, employees and service providers, or providing employee assistance programs to staff. Health professionals employed in these areas of workplace practice are also often members of multidisciplinary teams providing services to assist individuals to manage their injuries or disabilities and to return to or enter the workforce.

REFLECTION

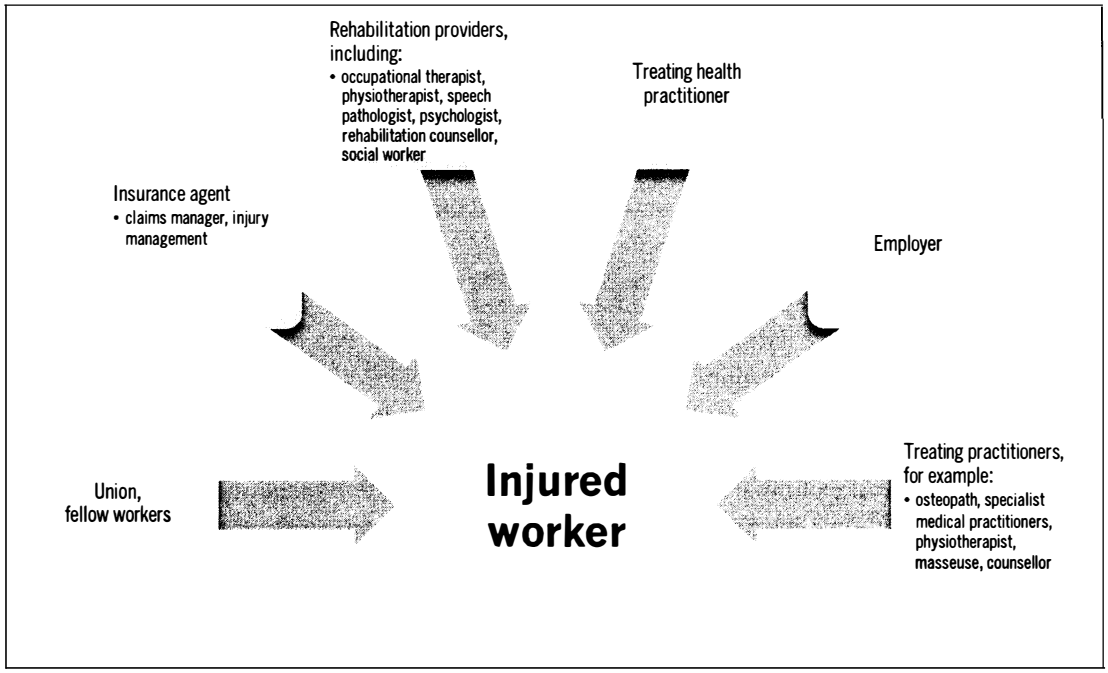
YOUR WORK EXPERIENCE

Have you worked or do you work in paid employment? Under what conditions and awards do you work? Are you aware of safety procedures at your place of work? What are these? Do you adhere to them?

OCCUPATIONAL REHABILITATION

Health professionals employed in **workplace rehabilitation** agencies aim to manage a process enabling injured workers to return to suitable employment in a timely and sustainable manner, based on assessment of their needs (HWCA 2008). Within Australia and New Zealand, workers' rights are protected by state and national workers compensation legislation. Rehabilitation consultants work within the guidelines of the relevant Acts to assist individuals to return to the workforce following a work-related injury. Rehabilitation consultants may also assist those individuals to return to work if they are covered by legislation such as compulsory third party, motor vehicle and military compensation schemes. Figure 20.1 shows the stakeholders in the occupational rehabilitation process.

Figure 20.1: Stakeholders in the occupational rehabilitation process



In occupational rehabilitation, unlike many other areas of health practice, the customer is often the insurance agent. It is the insurer who approves the services to be provided and payment for services, and dictates the timelines for meeting specific milestones. Although the rehabilitation consultant's aim is to assist the worker to return to work and address any identified barriers, this is performed in the context of claims management and under the guidelines of the relevant Act. The insurer will decide whether or not a rehabilitation provider can continue to provide services. At times rehabilitation consultants will be asked to withdraw from a case before they have achieved all that they wanted to or believed they could achieve.

As occupational rehabilitation is provided at most workplaces, you can expect to visit a variety of workplaces while on fieldwork. The purpose of these visits may be to meet with injured workers, the workers' supervisor and/or the return-to-work coordinator for the company. During these meetings information is gathered regarding:

› the injury
› current work capacity
› medical restrictions
› planned treatment
› social and psychological status
› usual work performed
› opportunity to provide or perform alternative duties at the workplace.

Often a worksite assessment is conducted following such meetings to gain an understanding of the specific physical, cognitive and environmental requirements of the usual and/or alternative job options for the injured worker. Following an initial assessment

visit, the rehabilitation consultant will write reports and prepare **return-to-work plans**. At this time, contact is made with other stakeholders, including treating health practitioners and the insurer. Depending on your course year level, this may be an area that you observe, but may be unable to undertake independently, or will have to complete under supervision. You may have limited opportunity for direct involvement in a case, because of current or potential legal claims.

Through observation you can begin to understand the processes involved and can identify the skills required to facilitate a successful return to work. Although it may not always be possible to conduct an assessment or provide counselling to a client, you may be able to practise this with your fieldwork educator or peers.

SUPERVISOR PROFILE

JANINE LANGLEY AND JANE VANDERSPIKKEN

Janine is an Occupational Therapist (B.App.Sc. OT), National Quality Improvement Manager. She has worked in the workplace rehabilitation industry for seventeen years, has supervised many student placements and lectured in Occupational Therapy—Workplace Rehabilitation at Deakin University (2009).
Jane is an Occupational Therapist (B.OT), Principal Consultant. She manages many complex workplace rehabilitation cases as well as supervising less experienced consultants.

1 *Tell us about your role. What does a typical day involve?*
Workplace rehabilitation are services provided to working aged people within a compensable or non-compensable arrangement with the aim of assisting a person with an injury or disability to successfully return to work or to become re-engaged in productive employment.

Health professionals working in this industry use different titles including injury management consultants, workplace rehabilitation consultants or occupational rehabilitation consultants. A variety of health professionals are able to work in this role, however, some schemes will restrict what services are able to be provided by what particular professional group.

These roles are available in urban and rural locations, within large national organisations through to small boutique companies.

Workplace rehabilitation consultants act as independent return to work experts who assist an injured worker to return to their pre-injury employment or to re-engage in alternative suitable employment.

Our role is as a facilitator assisting all parties to identify the issues influencing the return to work and to establish a collaborative approach to achieve the agreed return-to-work goal. Our expert understanding of the 'system' and injury, coupled with our communication and negotiation skills, places us in an ideal position to assist all parties to achieve the return-to-work goal.

Consultants deal with a range of physical and psychological injuries and disabilities ranging from catastrophic to serious or multifaceted injuries (i.e. back injuries, shoulder injuries, head injuries, often with associated psychosocial influences).

A typical day involves spending approximately 50 per cent of the time 'out and about.' For example: on worksites with workers and employers; attending meetings with key parties; facilitating case conferences with doctors or other treating health practitioners; attending meetings with the insurance company. The other 50 per cent of the time is spent in the office writing reports, liaising with key stakeholders and communicating via the telephone.

As workplace rehabilitation consultants are largely employed by private companies who provide services under a payment for service model, most companies will require a certain number of hours of 'billable work' to be completed per day.

2 *What are some of the challenges you face as a clinical supervisor?*

As a private company working under a regulatory fee for service model, no student can actually charge for service provision. This means a student is not able to perform servicing without direct supervision and informed injured worker's consent (e.g. a student is not able to conduct an assessment without an approved consultant also present).

Many students approach fieldwork placements from a 'worker advocate' viewpoint. However in the workplace rehabilitation setting, our role is to provide independent servicing, representing the needs of all key stakeholders. Students sometimes find this challenging as they try to integrate this concept with their professional viewpoints and philosophy. Students also commonly struggle with understanding and appreciating the complexities of a multi-stakeholder service where individual drivers often appear to be conflicting.

Another challenging factor is that a student's supervisor may not be from their specific profession. Some students find this difficult as they are not able to clearly define their unique professional role within this cross-health professional role.

As students commonly only attend placements for a six- to eight-week period they will rarely see the whole process for any individual worker and therefore gather a more 'disjointed' insight into the intervention of workplace rehabilitation.

3 *What is unique about this setting in terms of student supervision?*

Given the above factors, this setting is not considered appropriate for first and second year students due to the need to have a solid foundation in your chosen profession before trying to understand the complexities of the system as well as your professional identity within this system.

This setting will expose the student to a large variety of environments/ employment settings (i.e. visiting a variety of worksites, visiting treating health practitioners, etc.). The student will also have the opportunity to interact with a large proportion of the community: variety of ages, personalities, cultures, physical conditions and psychological conditions.

The key stakeholders involved in the process of workplace rehabilitation come from a variety of environments which are only joined by the workplace injury (i.e. insurance company, treating health practitioners, unions, employer etc.). It is the injury that links all parties together.

Although students need to be directly supervised during a placement they will have the opportunity to see how autonomous the role is and how, although you may work with other health professionals, you may be the only one from your organisation working with an individual worker.

4 *What clinical skills are important for this setting?*

The following clinical skills are very important within workplace rehabilitation:

- high-level communication skills including written, verbal and facilitation skills
- very sound clinical reasoning and confidence with communicating those clinical skills
- ability to consult with key parties and facilitate them, all working together as a team to ensure the return-to-work goal is achieved in an effective and appropriate manner
- high-level customer service skills and abilities, including the ability to manage multiple key customers with potentially differing agendas and drivers
- attention to detail including the ability to produce high-quality written reports suitable to be read by the multiple stakeholders
- ability to implement effective time management skills
- mature outlook enabling the ability to deal with stakeholders of varying ages and complexities.

5 *What are some useful resources for students to review prior to starting the placement?*

Third and 4th year students:

- *Nationally Consistent Approval Framework for Workplace Rehabilitation Providers*
- state-specific regulator websites as determined by the services the placement provides, i.e. WorkCover scheme, Comcare scheme, Centrelink scheme, Transport/Motor Commission (i.e. TAC, CTP, MAIB)
- *WORK* (journal)
- other university-based resources.

6 *What are some of the key learning opportunities available to students?*

There are various learning opportunities available for students including:

- how to complete initial and workplace assessments; ergonomic assessments; discipline-specific assessments (e.g. ADLs)
- how to write reports suitable for the regulator industry
- development of further communication, negotiation and liaison skills
- opportunity to see how a private company works and how organisations within the community function and manage return to work (i.e. you see workers and employers within their own work environment)
- exposure to other health professionals performing the same work tasks
- understanding the way consultants in this role play a very active and 'driving' role in the process, often leading case conferences and return-to-work planning meetings
- gaining 'real life' exposure to the work rehabilitation industry.

7 *What would you expect from a 3rd year or 4th year student on placement?*

It would be expected that while on placement 3rd and 4th year students:

- practise and prepare report writing on specific cases, with the rehabilitation consultant correcting and signing the report
- liaise over the telephone with all key stakeholders
- actively participate with their exposure to other facets of the industry and business, e.g. spending a half day with stakeholders such as an insurance company or attending return to work coordinator training.

Third year students only:

- by end of the student placement (i.e. five weeks) have the opportunity to conduct one assessment with direct supervision.

Fourth year students only:

- by the end of the student placement (i.e. eight weeks) to conduct approximately six assessments under direct supervision
- possibly to facilitate a simple General Practitioner case conference with supervision.

8 *What parts of the placement could students find challenging? What tips do you have for them?*

Common challenges students are likely to encounter and tips to overcome these challenges include:

- students understanding the complexities of the workplace rehabilitation system. It is recommended students come to the placement prepared with some basic knowledge of the scheme they will be working under. Additionally, it is important for students to understand they will not complete the placement understanding all the complexities of this industry (i.e. a placement will just give them a 'taste' of the industry)
- dealing with students' expectations and desires to be independent in an industry where this is legally not possible. It is advised that this is discussed with the student at the beginning of and throughout the placement. Students are still able to conduct assessments and write reports, however, direct supervisors are required in attendance at all times
- communication, negotiation and influencer skills are required. Students need to be able to draw together all clinical knowledge and facets of the case in order to guide all key parties towards the agreed return-to-work goals. Students are encouraged to clearly consider the clinical evidence, worker and employer needs and the physical and psychological demands of tasks in order to establish a clear plan of action
- effective time management skills are required. Students need to be well organised, keep track of what they are doing and discuss time management with their supervisor. Due to the above-mentioned considerations, time management will largely be driven by the supervisor. Additional tips include utilising driving time to discuss cases and being well prepared prior to completing initial assessments.

DISABILITY EMPLOYMENT SERVICES

Disability employment services aim to assist people with disabilities to find work and to maintain employment if their job is at risk due to a medical condition or disability. In Australia, a national scheme is funded by the Department of Education, Employment and Workplace Relations (DEEWR). Two specific programs are designed to establish local service providers to assist people who require a short-term intervention, or assistance over longer periods of time:

- Disability Management Service for job seekers with a disability, injury or health condition who require the assistance of a disability employment service but are not expected to need long-term support in the workplace.
- Employment Support Service for job seekers with permanent disability and with an assessed need for more long-term, regular support in the workplace (DEEWR 2012).

Allied health professionals may be involved in assessment roles, in offering long-term support services or as consultants within job-seeking programs.

CASE STUDY

A referral from the DVA

Joe, a 42-year-old ex-serviceman, was referred by the Department of Veterans Affairs (DVA) for assistance to return to meaningful employment. He presents with the following medical problems:

- psoriasis
- hearing loss
- anxiety
- depression
- bilateral hip arthritis
- alcohol abuse.

Additional issues include:

- recent marriage breakup, property settlement pending, limited access to children, living in temporary accommodation
- withdrawal from social network, few interests, working part-time in a job he doesn't enjoy
- has applied for eighty jobs over two years; has had eighteen interviews but has been unsuccessful
- sensitivity to products containing formaldehyde, such as photocopiers, chipboard, new carpets.

You have been observing your fieldwork educator interviewing Joe, and feel overwhelmed by all the issues that need to be considered to keep Joe at work. After Joe has left, your fieldwork educator turns to you and asks you:

- 'What are the barriers facing Joe?'
- 'How do they have an impact on his ability to work?'

- 'What interventions could you recommend to address these?'
- 'How do you ensure all key stakeholders remain connected and aim for the same outcome?'
- 'What strategies would you put into place to try to keep this man at work?'

You feel a little stunned, because you are still coping with all the issues that confront Joe. Your fieldwork educator recognises that you are not sure where to start, so she begins to discuss some of the actions that may be taken by a health professional in this scenario.

These include:

- liaison with the treating health practitioner and other treatment providers, such as counsellor to establish the prognosis for each of his medical conditions, and to seek information relating to suitable work guidelines and restrictions
- monitoring the effectiveness of current strategies in place to deal with Joe's social problems; referring Joe on to other qualified service providers to address some of these issues if necessary, such as alcohol rehabilitation, personal counselling, involvement in social activity (community or support groups) and legal consultation
- preparation for job seeking: clarify suitable work areas, write new resume, provide interview practice, provide education and/or counselling regarding disclosing details of his disability to potential employers, and answering questions related to his personal life in a way that doesn't create emotional distress during a job interview situation
- providing job-seeking assistance: identify job vacancies, review job application letters, investigate and apply for employment incentives and specific employment-related programs if available
- supporting and monitoring the client throughout the rehabilitation process and once employment is obtained
- maintaining regular communication (verbal and written) with all stakeholders, and ensuring all parties are in agreement and aware of this man's rehabilitation goals.

REFLECTION

JOE

Did you think about the questions on Joe's plan before you read some solutions? How would you implement the solutions suggested by the fieldwork educator?

Joe will require ongoing case management. Ongoing case management tasks would include writing progress reports, liaising with key parties to seek or provide information to progress the case, checking that funding is available and planning timelines are still valid to ensure the rehabilitation provider will be paid for the services provided. You will also need to record the time spent on the case, and invoice DVA monthly.

CASE STUDY

Workplace safety

You visit a car-manufacturing factory with a psychologist and an occupational therapist to consult with management as part of a plan to improve workplace safety and integrate a second factory into the operations. You have been informed that the second group of workers (from the second factory) is unhappy about moving locations and being asked to take a pay cut to work at a lower classification.

The psychologist aims to advise management about how to introduce the second group of workers to head off issues of job uncertainty, competition, poor communication and poor morale.

The occupational therapist has been asked to undertake a workplace assessment to evaluate the work currently performed and the working environment, and to make recommendations to improve workplace safety and minimise the risk of injury.

As you move around the factory with the health professionals, you notice what appears to be a worker removing a guard from one of the process lines. Before you have time to investigate further, you are taken into an office to meet with representatives of management.

Immediately you feel tense in the stomach. Several questions arise about your role as a student in this situation:

1 What should you do about what you have seen?
2 Is it your place to mention the apparent tampering with equipment and resultant safety hazard?
3 If you do raise the issue, who should you talk to and when?

REFLECTION

UNCERTAINTY

Have you ever had an experience where you were not sure about the boundaries of your role—how you should act, if you have the authority to speak out and the scope of your responsibility? Have you ever experienced conflict between your professional, moral, ethical and legal responsibilities? Should there ever be a conflict between these four responsibilities?

In a situation such as Case Study: Workplace safety, it is important that you are reasonably certain about what you have seen and not jump to conclusions. It would not be appropriate to interrupt the meeting and state your suspicions or speak in an accusatory manner in front of management. It would, however, be appropriate to mention to the health professionals privately, and as soon as possible, what you saw or thought you had seen. This would ensure you act professionally and are meeting your duty of care obligations to do what you can to facilitate safety in the workplace.

If after investigation you conclude that there was no risk to workers, the worst thing that could happen is that you have increased your knowledge of workplace safety and the method of assessing potential hazards.

You should be encouraged to raise your observations and uncertainties with the fieldwork educator; however, this needs to be done in a non-judgmental way and at an appropriate time and place.

CASE STUDY

The negotiation

You have accompanied a rehabilitation consultant to a workplace and are sitting in a boardroom observing the negotiations taking place between the employer and an injured worker. The **negotiation** is being facilitated by the rehabilitation consultant, who has recommended what she believes to be suitable hours and duties for a return-to-work plan. It is apparent that the worker is resistant to returning to work, and the employer is prescribing the limited options available. The employer is only interested in returning the injured worker to his pre-injury duties, and will not consider flexible work hours.

When the group breaks for coffee, the worker begins talking to you. He reveals that he is planning to sue the employer for negligence. He plans to exaggerate his incapacity in the hope of getting a larger sum awarded to him.

REFLECTION

DILEMMA

The worker has just informed you of his intentions to sue and exaggerate his incapacity (see the above case study: The negotiation). You try to stay calm and composed. What should you do in this situation? Should you mention to the injured worker's supervisor what has just been said? What should your immediate response be to the injured worker?

An appropriate response

It is important that the rehabilitation consultant knows about the information given to you, as this could have a serious impact on the return-to-work program. It also gives an insight into the reason behind the hostilities between employer and employee. You should discuss this with your fieldwork educator; however, do this privately and at an appropriate time and place.

You need to remain professional at all times and not be drawn into the worker's plans. As you must remain objective and impartial, an appropriate response to the worker might be, 'It is important that the rehabilitation consultant knows this. Would you talk to her about this after the meeting?' You could then politely excuse yourself from the conversation, thereby limiting the opportunity for further dialogue when the rehabilitation consultant is not present.

COMPETENCIES REQUIRED FOR WORKING IN WORKPLACE PRACTICE

Health professionals require a range of skills to be effective providers within employment services and occupational rehabilitation. You bring a depth of education and personal development that shape your skills according to your professional area. There are some common or generic competencies that are important for workplace practices, and especially for case management roles. The knowledge and skills you will draw on include communication, workplace practice analysis, management and knowing the system.

Communication includes:

- written and verbal communication
- negotiation and mediation
- motivating clients.

Workplace practice analysis includes:

- observation: of work environments, processes, worker performance
- task analysis and assessment
- awareness of the importance of outcomes and program planning
- understanding relevant health conditions: their functional, psychological and social implications and likely treatments.

Management includes:

- computer proficiency
- time management and general organisation
- problem-solving abilities
- leadership (ability to facilitate progress and drive the process)
- managing budgets and costing services
- having a customer focus.

Knowing the system includes:

- knowledge of income support services
- knowledge of the relevant legislation and requirements for reporting.

The health professional's role in workplace rehabilitation and associated workplace practice areas is to provide expertise to facilitate the return-to-work process. You will observe many activities during a workplace fieldwork placement. Although they will vary according to the nature of the injury and individual circumstances, these activities could include:

- assessment of worker needs, functional capacity and cognitive abilities
- counselling of injured workers
- analysis of job tasks and work environments
- negotiation of return-to-work plans, including advice on timing, range of work tasks and issues of safety
- monitoring return-to work-programs through regular communication and/or worksite visits
- education of stress management techniques
- conflict resolution
- coaching and training
- work conditioning
- case management, including managing a program, seeking funding, invoicing and liaising with all stakeholders
- report writing
- provision of job-seeking assistance; for example, preparing resumes, conducting interviews, and providing education to clients about job seeking and helping them to acquire or improve the required skills.

FIELDWORK PLACEMENT AREAS

You may attend a number of different fieldwork placements to expose you to the area of workplace practice and to apply and consolidate your knowledge and skills in these areas. Placements may be alongside other health professionals in a hospital or with a workplace rehabilitation provider, or you may be placed in a workplace where you observe a variety of work operations, practices and environments. Traditional health placements, such as hospitals and community health settings, can provide you with the opportunity to assess and provide interventions for an individual of working age who requires assistance to keep or return to his or her job.

Preparation for fieldwork

You will gain a great deal from your fieldwork placement if you are willing to observe and understand the work area you are observing. When undertaking a placement in the area of workplace practice, it is recommended that you prepare prior to commencement. For example, you can:

- research the workplace or industry being visited to gain an understanding of the scope of the work undertaken, workplace hazards and types of injuries that are prevalent in the industry. This information can generally be found on websites, through company annual reports and from occupational health and safety/workers compensation authorities; for example, WorkSafe Victoria or WorkCover NSW
- become familiar with assessment checklists used by health professionals
- become familiar with the relevant legislation; this will assist your understanding of the purpose of the referral and what is expected to be achieved. In particular, look at the rights and responsibilities of employers and employees, as this will help you gain an understanding of the requirements and motivations of these key stakeholders
- read client files before an appointment in order to understand the background to the case, and question your fieldwork educator if it is not clear what is taking place
- familiarise yourself with the current labour market, including where current job vacancies appear and areas of skill shortage.

Student behaviour

As in any other area of fieldwork, you are expected to display professional and appropriate behaviour at all times while on placement. It is important that you consider the environment, and dress appropriately. For example, if you are visiting a refrigerated meat-processing plant, dress for cold conditions and wear appropriate footwear and clothing. You should also consider the mix of workers (male and female) and the culture of the workplace, and ensure your clothing is appropriate.

You must protect the privacy and confidentiality of your clients, and carefully store and, where necessary, destroy all written materials, notes and assessment forms according to the agency policy. You must be mindful of commercial confidences and not publish or talk freely about the practices of the workplace you have visited. In addition, you must consider the sensitivity of the information received, and communicate information with sensitivity and professionalism.

THINK AND LINK

Chapter 2 outlines your responsibilities as a student on placement. Protecting privacy and confidentiality of clients in all placements is a vital part of your professional behaviour and is also discussed in Chapter 12.

When writing reports and case notes, be careful to ensure that what is written is accurate and objective. In the area of workplace practice, the likelihood of a health professional being subpoenaed to court is increased because of the high levels of legal action taken by injured workers, employers and insurers.

Familiarise yourself with the workplaces you are visiting, and comply with the site-specific occupational health and safety requirements. For example, if hard hats, hearing protection and high visibility vests are required, you must comply for your own and others' safety.

THINK AND LINK

Undertaking fieldwork placement in services where fees are charged changes the relationship between the client and the student. Chapter 21 discusses fieldwork placements in private practice, highlighting what is different about this context of fieldwork experience.

SUMMARY

Undertaking a fieldwork placement in workplace practice will expose you to the development of many competencies and a specific type of health service. When working with individual clients (that is, injured workers or job seekers) you will be learning about the health conditions suffered by clients, including likely prognoses and treatments. You will learn about legislative systems, such as workers compensation, transport or accident compensation schemes. You will be undertaking a placement where customers are usually insurance agents who have asked rehabilitation providers to provide a certain service. In workplace practice, you will need to discuss with your fieldwork educator whether there are any conflicts between stakeholders. These stakeholders are the worker and employer, and worker and insurance company.

You will learn the format of writing case notes or reports, and you should welcome your fieldwork educator's comments on your writing so that you learn to be objective in your written and verbal communication. You will learn about negotiation, and how not to make promises to workers or employers, as you are a student on placement. You will, however, discuss with your fieldwork educator the scope of your job. In these situations, you should be keenly aware of your professional boundaries and the need to not give advice beyond your level or area of expertise. You will gain experience in case management roles, which is a growing area of practice in many allied health professions.

Discussion questions

Set up a role play between an injured worker, an employer and yourself, a rehabilitation professional. The injured worker wants to talk to you about his dislike of the employer, and starts to make accusations about the employer and the safety procedures at work.

1 How do you professionally keep a distance between yourself and the injured worker?

2 What would you say to the injured worker?

3 Discuss several ways to keep your professional boundaries when in conflict situations and under pressure.

Portfolio development exercise: Preparing for workplace practice

These exercises are designed to be completed for your portfolio prior to going out on a workplace rehabilitation placement.

- Exercise 1: Research the relevant workers compensation legislation in your region (internet search). Choose an area of employment, for example health services, and list the common injuries found in this industry. Are there codes of practice that aim to reduce these injuries? If so, list some of the prevention strategies you would expect to see in a workplace.
- Exercise 2: Look back at Case Study: A referral from the DVA. If you were planning a placement with Joe's rehabilitation provider, what do you expect will be the areas of interest for your supervisor? List the competencies you already have to observe the intervention you predict would be important for your discipline area.

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Michelle Day (Conlan) was the author of this chapter in the first edition of this book and this second edition chapter builds on her previous work.

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Heads of Workers' Compensation Authorities (HWCA) (2008). *Nationally Consistent Approval Framework for Workplace Rehabilitation Providers*. Retrieved 10 August 2012 from www.hwca.org.au.

FURTHER READING

Journal of Occupational Rehabilitation

Journal of Vocational Rehabilitation

WORK: A Journal of Prevention Assessment & Rehabilitation

USEFUL WEBSITES

Accident Compensation Corporation: www.acc.co.nz

Australian Psychological Society: www.psychology.org.au

Comcare: www.comcare.gov.au

CRS Australia: www.crsaustralia.gov.au

Disability Employment Australia: http://disabilityemployment.org.au

Heads of Workers' Compensation Authorities: www.hwca.org.au

Job Services Australia (DEEWR): www.deewr.gov.au/employment/jsa/Pages/default.aspx

My Career: www.mycareer.com.au

NT WorkSafe: www.worksafe.nt.gov.au

Occupational Therapy Australia: www.ausot.com.au

Safe Work Australia: www.safeworkaustralia.gov.au

WorkCover New South Wales: www.workcover.nsw.gov.au

WorkCover WA: www.workcover.wa.gov.au

WorkSafe Victoria: www.worksafe.vic.gov.au

CHAPTER 21

Working in Private Practice

Tim Kauffman, Phoebe Maloney and Adrian Schoo

LEARNING OUTCOMES

After reading this chapter you should be able to:

- discuss how private practice settings differ from traditional placements
- recognise the importance of private practices as treatment centres
- appreciate the transition from an academic to a clinical education
- understand the challenges to you as a student in a private practice setting
- understand the opportunities for students and practitioners in the private practice setting.

KEY TERMS

Entrepreneurial
Private practice
Private practitioner

INTRODUCTION

Fieldwork placements are crucial to your professional development as a health professional student. At present, one expanding area of health education is the delivery of physical and occupational therapy programs that explore the use of **private practice** settings as learning opportunities for students. In general, private practice is autonomous, **entrepreneurial** and possibly lucrative; but it is also challenging, litigious, and takes the capital and resources of the **private practitioner** to establish it, with some of them going into debt as they build up their private practice. These factors make work-integrated learning in a private practice different from a hospital or clinic setting. Also, the privately owned practice is not identical

to the hospital-established outpatient clinic, the physician-owned practice or the corporate-owned franchise. Such settings reduce or mitigate the autonomous and entrepreneurial nature of practice, and reduce the personal risks to capital and resources. This chapter will introduce you to some of the similarities of and differences between fieldwork placement experiences in private practice settings compared with the more traditional hospital, clinic or ward settings.

Private practice is growing as a health service area. For example, the worldwide importance of private practice is evidenced by the nineteen member countries in the International Private Practitioner Association (IPPA), a subgroup of the World Confederation of Physical Therapy (IPPA 2012).

WORK-INTEGRATED LEARNING AND THE STUDENT

Work-integrated learning takes place within a practice environment that is focused on providing cost-effective, high-quality care, as well as education for patients and their families. One very important factor to recognise is that fieldwork educators usually are not paid for teaching students, and this can influence the decision of the private practitioner to accept or refuse students. In 2009, a survey of allied health professionals in rural settings was undertaken to gather data on the challenges and opportunities of supervising students in a private practice (Maloney 2009). Findings of this study, indicated that practice profitability influenced decisions not to supervise students and 61.1 per cent of private practitioners reported that financial recognition for supervising students would encourage them to supervise in the future (Maloney 2009). Nonetheless, fieldwork educators in all settings have the responsibility for assisting you to make a transition between academic learning and clinical skills with real patients or clients.

You must be actively engaged in fieldwork learning, and this includes setting specific learning objectives with your fieldwork educator. On placement in a private practice, it is important for you to have a reasonable level of personal autonomy and independence. Working in private practice involves varying amounts of client contact time and time spent fulfilling other administrative and business responsibilities. To make the most of your private practice placement, it is important for you to be willing to accept fluctuating levels of client contact time, and be prepared to use your 'down time' productively. The end result is you becoming a graduate who can undertake clinical decision-making based upon knowledge and clinical skills, and also demonstrate professional competencies such as interprofessional communication and self-directed learning.

THINK AND LINK

Undertaking a placement in a private practice setting will introduce you to a range of new skills. Chapter 5 provides information and some reflections on how to capitalise on your learning opportunities.

CHALLENGES AND OPPORTUNITIES

The competencies required to provide care to clients in a private practice setting are similar to those in other settings, but also include financial requirements that are often not experienced in other healthcare settings by health professionals. The financial considerations are similar to the business skills required by the manager of a clinic in a hospital setting. In a private practice experience, you may have more opportunity to be exposed to business issues, including fees, target revenues, costs for labour, taxes, equipment, supplies, overhead, medico-legal concerns and marketing. These concepts can be invaluable for later career decisions about going into one's own practice or moving into management.

Often in the private practice setting, there is a reluctance to accept students because of a sense of greater liability (Doubt et al. 2004), but this may be illusory, because there are fewer layers of management than in large health centres. As Jette and colleagues (2007) indicated, safety is a crucial issue in health settings. Maloney (2009) found that the top three reasons given by private practitioners to supervise students were: the level of clinical skills and experience of students (23.6 per cent); benefits to the professional's own clinical skills and experience (20.8 per cent); and their past experience supervising students (18.1 per cent).

In many countries, clients can now enjoy direct access to therapy and other health services without a physician's referral. This is becoming more common; a World Confederation of Physical Therapy (2003) report indicated that the outcomes of educational programs in Australia, Brazil, Canada, Jamaica, Norway and South Africa are intended for graduates to work autonomously and/or in primary care (Takahashi et al. 2003). Forty-six states of the USA, the District of Columbia and the entire military system permit direct access to physical therapists who have received special training and licensure.

But this access to direct primary therapy care increases risk, especially in a litigious society like the USA. This is more of a concern in private practice, which does not have the protection given to large hospital or national health systems. Private practitioners also must pay their own insurance, which is often high. On the other hand, a large study involving direct access by 50,799 patients in US military healthcare facilities showed no adverse events for patients or therapists. There were no licence, credential, litigation or disciplinary actions for the physiotherapists working in military facilities (Moore et al. 2005).

Other challenges that you may encounter in the private practice setting include the difficulty of supervision at all times and the patient paying for service. In the USA in particular, some insurance companies and specifically Medicare, the national health insurance system for most persons over the age of 65 years, clearly state that students may not treat Medicare beneficiaries and bill for those services unless they are directly supervised in the room by a licensed practitioner. This requirement has had an adverse effect on the training of students in private practice in the care of older persons. Similar concerns were found among private practice physiotherapists and occupational therapists in Canada (Doubt et al. 2004).

The requirement for you to be supervised at all times when treating patients or clients in private practice presents time constraints for the fieldwork educator, and may discourage private practitioners from working with students. In the 2009 survey (Maloney 2009), the top three reasons given by private practitioners for deciding not to supervise students were: time taken from productive work directly with clients (43.1 per cent); concern with client

satisfaction in being seen by a student (27.8 per cent); and practice productivity (22.2 per cent). When the concerns of all 72 professionals were taken into consideration, time taken to supervise a student (72.2 per cent); the client's willingness to be treated by a student (51.4 per cent); and workplace productivity (43.1 per cent) were cited as the top three barriers in supervision of students. These findings agree with Doubt and colleagues (2004) that 'time is money'.

Also, some private practices have concerns about their reputation in the patient population and among their referral sources; thus they do not want students to treat their patients. This may become more problematic when the patient does not get fully refunded from a health fund. For example, ten years ago for physiotherapy the patient only paid $5–15 in the Northeast USA. Now it is $10–50. Do patients feel they are 'getting their money's worth' when they are treated by a student? This may become more problematic, as health insurance companies or possibly health funds require patients to make a payment for each date of care.

SUPERVISOR PROFILE

PEARSE FAY

Pearse Fay is a Bachelor of Occupational Therapy, La Trobe University; Accredited Occupational Therapist; Associate Member Australian Hand Therapy Association; and Member of Occupational Therapy Australia. He is a Lecturer in Occupational Therapy, Deakin University, and Clinician in Hand Therapy, Geelong Hand Therapy.

1 *Tell us about your role. What does a typical day involve?*

I work two and a half days at a university and two and a half days at a private hand therapy clinic. Currently my role at the private hand therapy clinic involves seeing private and compensable patients who have suffered an injury/disease to the upper limb. The injuries vary greatly and can be significant trauma cases where digits have been lost and surgically reattached to less traumatic cases such as wrist pain from poor positioning at work.

I work long hours on some days (8 a.m. to 7.30 p.m.), while shorter hours on others (2 p.m. to 7 p.m.). My appointments are generally back to back and vary from 40 minutes for an initial appointment to 20–30 minutes for a review appointment.

2 *What are some of the challenges you face as a clinical supervisor?*

Currently the most challenging aspect I encounter is engaging with students who have the expectation that they deserve to be 'given' the experience(s) that occur on fieldwork rather then 'working' on gaining the experience. Therefore as a supervisor I feel that the expectation upon me is to be constantly giving the student information/experiences/roles rather than the student seeking out experiences and information. By identifying this early in a placement and addressing it with the students, the students have responded extremely well and changed their approach to fieldwork.

Time is another significant issue. In a private practice I am rushed for time the majority of my day. I like to give students the time they need when I have them in the

clinic so this places even more strain on my time. In the early weeks of a placement I will spend anywhere between 5–10 minutes extra with a patient as I explain aspects of injury/treatment to my student. Having back to back patients, this can cause challenges with me running late and patients becoming frustrated in the waiting room. But as a positive I feel that the patient sometimes gains from the experience, because as I teach my student, the patient gains knowledge/information which I may have not gone into if I did not have a student.

Finally having students treat in a private clinic can be difficult. Patients who attend a private clinic are paying and generally have the expectation of seeing a professional with experience. Having a student treat can challenge the expectations of the patient. This is not always the case but can be difficult. On the rare occasion a patient will say 'No' to having a student in the session. More frequently, patients will be unhappy with the student taking the lead role in treatment. So, to make this a positive experience for student and patient, I sometimes give the patient more time by completing the session and then have my student continue on with further treatment, which the patient would not have received 'normally' from me.

3 *What is unique about this setting in terms of student supervision?*

My setting is unique as it is a small private business. Within the clinic there is generally the administration officer and myself. Therefore it's a much quieter environment, which students may not have seen before. The environment does not have direct physical links to other professionals and this means that phone calls and emails are how we communicate to everyone else involved in the patient's care.

The business aspect is unique in this setting. The skill of running a business is required on top of the skills of being a health professional, e.g. taking payments, booking appointments, ordering stock. These are also skills that students may not have used before or discussed at university.

Working hours is another unique factor, as I have days where I start in the afternoon and work through to 7.30 p.m., and other days I start early and work 10 hours, as well as working Saturdays. For students this requires them to be flexible and sometimes they will need to work on projects from home or in the office until a patient booking occurs.

4 *What clinical skills are important for this setting?*

As an occupational therapist working in hand therapy I require professional behaviour skills plus skills unique to hand therapy, e.g. splint fabrication.

I gather the information required to understand what has happened to my patient; this may be through reading referrals, operation notes, assessment of the upper limb and most importantly discussion with the patient. Throughout this process I am painting a picture of what happened to this person, who they are and how the injury has affected what they can do. So gathering information and putting it into a 'useable' picture is the first step.

Once I have gathered information I then need to analyse how the injury/illness/disease is impacting upon the person, and work out what I can do to help. Experience in hand therapy and knowledge of conditions and treatments are vital in this step.

Once I have worked out an appropriate treatment, the next skill is by far the most important—explaining it. The competency of communication is most important. The people we treat don't have the knowledge we have and so often they do not know what is happening unless we communicate with them. So the skill to communicate that you have heard what they have said, that you have knowledge of their injury/illness/disease, that you have a treatment plan for them and that you will be able to improve their situation to allow them to return to their roles, activities and life is essential. The skill of communication can calm people, motivate people, teach people and in the end 'treat' people.

Some unique skills for hand therapy are: fabrication of splints, knowledge of designs, material, and looking for new material and techniques as well as remaining motivated to keep looking for these.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*

Professional skills are important for placement. In 1st and 2nd year, readings on professional behaviour is the priority followed by clinical knowledge. The texts that assist with this are best supplied by the university and in accordance with the course structure.

First year student: It is important not to overload 1st year students. I prefer to have students observe and discuss what they see, participate where appropriate and in general work out what occupational therapy (OT) is about and what we do in the field of hand therapy. The student at this early stage will benefit from just simply 'being' in the situation; feeling what it is like to be in a clinic, seeing injuries and hearing professionals talk. At this stage, I prefer to provide students with reading on a specific condition, e.g. carpal tunnel syndrome. This allows them to have some knowledge of a condition, then with this knowledge listen, see and experience how the professional transfers this knowledge into useful information that the patient can understand and use.

Second year student: I expect students to have base knowledge of the OT role. I discuss with them aspects of professionalism and ensure that they have read texts that describe the skills required to be a professional. At this point more in-depth information on hand therapy, particularly anatomy, allows students to both understand the beginnings of hand therapy and to build upon professional skills.

Third year student: For 3rd year students I provide pre-readings prior to the commencement of fieldwork. Readings are focused on specific hand therapy information including 'Rehabilitation of the hand' and hand therapy journals. I ask for what gaps they feel they may have in their professional skills and then look at addressing these.

Fourth year student: I provide basic hand therapy information and I set learning goals with the student.

6 *What are some of the key learning opportunities available to students?*

In a private hand therapy clinic there are numerous learning opportunities such as:

- the direct observation of an experienced OT working with a variety of patients with upper limb conditions

- the chance to work in one specific area means the student can practise their professional skills while also gaining specialist knowledge
- the opportunity to see and assist in the running of a small business
- liaise with a variety of stakeholders including the patient, the referrer [GP, surgeon], occupational rehabilitation companies, insurance companies
- ability to follow patients through over time and see them progress.

7 *What would you expect from a student on placement?*

First year student: basic understanding of OT, with minimal professional skills but good life and study skills.

Second year student: Good understanding of OT, basic professional skills, ability to communicate in a semi-professional manner with patients, families and other professionals. Basic skills in documentation.

Third year student: Consolidated skills in communication, documentation and professional skills/behaviour. Good understanding of the breadth of their profession with interest in investigating specific roles and knowledge in different fields, e.g. neuro, hand therapy, aged care or community rehabilitation.

Fourth year student: Self-motivated, with a want to fill gaps in knowledge. Clear understanding of their profession and an interest to increase understanding in specific fields. Independent with communication, documentation and professional behaviours to new graduate competence. Basic understanding of their profession within the health system and issues that will impact upon the profession.

8 *What parts of the placement could students find challenging? What tips do you have for them?*

The initial anxiety of being in a new environment, with new people, new knowledge and new roles is stressful, plus the added pressure of a short time in the placement and being assessed can be anxiety provoking. So, the initial challenge is to reassure students that what they feel is normal and it will soon subside.

Dealing with patients in a small confined area such as a hand therapy clinic may be a new experience for some students.

The under-estimated skill of being able to create a relaxed environment with your patient by using 'small talk' is a skill that some students find difficult. Because students are conscious of trying to remember everything they need to know and do during a treatment session they can forget to talk. Reminding students to be aware of how the patient would be feeling and how their behaviour will influence the session is important.

Being exposed to difficult patients, wounds, emotional and sad stories can all be new experiences that a student must face, and their reaction to these situations may vary greatly.

Finally, students accepting that they know a lot but that they also have a lot to learn may be difficult for some students. There are many challenges that students will face. Acknowledging them as soon as they occur, being direct with students and reassuring them ensures the challenges are addressed appropriately.

CASE STUDY

Be quick in private practice

A physiotherapy student, who was in her final year, was asked to evaluate a client with multiple sclerosis. The student prepared for this responsibility, but failed to realise the importance of time that pertains to the clinic's schedule for the treating therapist and for the client who may need to return to work. The student in this case performed a comprehensive but not fully focused evaluation that lasted 3½ hours and could have gone longer. The student was doing everything she was taught in the academic setting, and the client, in this case, was enjoying the personal attention. However, the fieldwork educator had to stop the session because it was unrealistic for an evaluation to take so long. The student still had not focused on any specific problem and plan of care. Most importantly, the client was also exhausted and the student failed to recognise it. In this circumstance an inordinate amount of therapist's time was spent on this one case and student. Despite the length of time, the clinic was going to be paid a set fee for an initial assessment, not for the full 3½ hours.

QUESTIONS

1 What are three reasons why the fieldwork educator intervened in the evaluation being conducted by the student?

2 Why is time a crucial factor in private practice?

3 How could the student prepare for the session to be more time efficient?

In the private practice setting, you usually have to deal with the requisite issues concerning time spent and charges: 'billable units'. This, however, can be an opportunity instead of a challenge, since you have a chance to learn some business skills and financial management competencies.

Another opportunity during fieldwork placement in a private practice is the increased exposure to skilled and reputable practitioners, which may lead to future opportunities, including employment in that private practice. The same may be true in other fieldwork placement settings. However, the challenge may be to acknowledge that not all clients are comfortable with students, especially when the client is seeking and expecting care from an experienced and recognised therapist. Usually, this can be surmounted by the student working together with the therapist, which allows the student to demonstrate knowledge. Often clients are pleased to get extra attention from two persons. Having said that, whether you are on placement in a public or a private setting, client privacy and confidentiality should be at the core of all good therapeutic practice. It is a good idea to ask your clinical supervisor about client–practitioner confidentiality policies before commencing any work pertaining to clients.

CASE STUDY

Pleasing the client

A middle-aged woman with osteopaenia researched the internet and the community to find a specialist to evaluate her risks and abilities and to establish a plan of intervention. The client was quite pleased because she found a therapist in her community who had spoken internationally and has published work on the subject of osteoporosis and bone health. Before proceeding with the evaluation, the specialist asked the client if she would permit a student to observe and participate. The client consented. During evaluation, many questions were asked by the client, and the specialist answered by speaking to the client and the student. Also, the physical findings, as well as palpation, were shared with the student. The specialist and the student felt the session went well.

Three weeks later, when the client returned for a review and to advance the intervention program she complained that she was frustrated with the time and focus that she felt was taken from her and spent teaching the student. From the specialist's perspective, the time spent explaining, answering and teaching was aimed at the patient and the student, and was beneficial to both. In this case, despite asking the client's permission to allow the student to participate, it presented a challenge.

QUESTION

1 How would you deal with this situation? What factors need to be considered for the best interests of:
   - the client
   - the student
   - the practitioner
   - the private practice?

You may have the opportunity to observe and learn entrepreneurial skills and autonomy of practice when undertaking a placement in a private practice. In the future you may establish your own private practice. Observing a successful private practitioner is one of the best learning experiences for establishing one's own private practice.

One serious professional issue in any fieldwork education setting is the possibility of losing the focus of work-integrated learning. Some practitioners and managers may purposely understaff their clinics with licensed and expensive personnel in order to reduce their costs or to maximise their profits. Students can be used in this setting to offset those expenses. From an ethical perspective, this is improper.

SUMMARY

Fieldwork education is a crucial stage in the development of a profession. Private practice settings offer you experience in working in a business where fees, time spent with clients and quality of client care become a high consideration in practice. These considerations make

fieldwork placements in private practice distinctive compared to other settings. In private practice settings you will be more closely supervised and may find that you observe more often than interact directly with clients.

Discussion questions

1 What do you think you would learn in a fieldwork placement in a private practice compared to a hospital setting?

2 How would you balance learning from the client and fieldwork educator with the pressure of time and the concept of 'time as money'?

Portfolio development exercise: Getting prepared for private practice

- Discuss the differences between the private practice and traditional settings as well as the implications for the student being trained in a private practice.
- Do you think there are different expectations from you as a health professional when you work in a private hospital or in a public hospital? If so, can you explain why?
- We can assume that hospitals and other major health service providers have good management and governance structures in place to ensure viability of services and staff security. Can you explain what that looks like? Who are the decision-makers who carry the responsibility for a major health agency such as a regional hospital? What does the agency need to do to remain viable?
- How does this translate to small private practice? What do private practitioners have to do to provide a respected and sustainable service to members in the community? Can you list as many costs and benefits as you can think of?
- Now you have started to gain an appreciation of private practice, what do you think will be the expectations for you as a student when you wish to spend some time in private practice as part of a fieldwork placement? Are there any other implications you can think of?

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CHAPTER 22

Working in Rural and Remote Settings

Paul Tinley

LEARNING OUTCOMES

After reading this chapter you should be able to:

- discuss and contrast health issues in rural, regional, remote and metropolitan areas
- prepare for a fieldwork placement in a rural or remote setting
- discuss professional behaviours while on fieldwork placement.

KEY TERMS

Accommodation
Professional standards and image
Remote and rural health settings
Royal Flying Doctor Service (RFDS)

INTRODUCTION

There are currently many government initiatives to promote practice in rural health settings, as this is seen as a 'priority area'. As a health professional student, you will most likely be asked to attend a fieldwork placement in a regional, **rural or remote health setting** as part of your professional entry level course. These fieldwork placements can appear exciting and challenging, but if not carefully managed, they can become problematic. With the correct preparation and your flexibility, these placements can be very rewarding, with lots to be learnt and experienced. The rural experience will throw you out of your comfort zone, so knowing how to adapt will be an important part of success in these environments.

Before giving some useful hints and tips to surviving and getting the best out of your rural experience, we discuss the issues and problems of life and health in rural practice. Perhaps this chapter should be called 'Don't Get Sick in Rural Areas'. The framework presented in this chapter, together with the suggested background reading, needs to be considered before you take part in a rural or regional fieldwork placement.

The lie of the land in rural and remote Australia

It is important to understand the 'lie of the land' before you can fully appreciate why things happen differently in the rural and regional environment. Below are some useful data on rural health problems, access and numbers of rural health professionals in Australia. It is important to understand that these data (from Australian Bureau of Statistics 2006) are based on the Australian experience, and may not apply to other countries. For other countries, please check the relevant population demographics to give you the required snapshot of the population in which you will be working.

Australia has one of the most urbanised populations in the world. With 70 per cent of the population living in capital cities and major metropolitan areas, most of the population lives within 80 kilometres of the sea, making vast areas of inland Australia sparsely populated. Fifteen per cent of the population lives in or around major regional centres and 14 per cent lives near country or coastal towns surrounded by agricultural areas. Only 1 per cent of the Australian population lives in remote areas.

While city populations are increasing relatively fast, rural and remote populations are showing growth of less than 5 per cent per annum, and in many cases there is even a decline in growth. This means that there is a relative population change in rural areas with many people leaving rural and remote areas for cities and regional centres. This trend is particularly common in the younger population. Reasons for this include job accessibility, improvement in lifestyle and greater access to medical and social activity.

When we look at the 1 per cent of the population living in very remote areas, 40 per cent of this population is Indigenous. This compares with 5 to 25 per cent of the population in rural and remote areas being Indigenous, with less than 5 per cent in metropolitan centres being Indigenous. Rural populations also have greater numbers of children, but lower numbers of young adults. Younger adults form the population group most likely to be moving away from their rural townships and communities.

Other differences between rural and metropolitan areas are educational standards. Rural areas have generally lower educational standards than metropolitan centres. This may be a result of access issues, and in areas with high Indigenous populations perhaps lack of attendance due to cultural stigmas. Rural areas have lower employment levels (less work available) and lower family incomes.

In general, food prices in rural and remote areas are 10 to 23 per cent higher because of transport costs, which means that there are fewer healthy food choices. Unhealthy food is generally cheaper than healthy foods, and use of tobacco and alcohol are an accepted part of life with 80 per cent of the adult population of Indigenous people being smokers.

Rural populations are involved in lower levels of physical activity, have greater levels of obesity, smoke more, drink more alcohol, have higher blood pressure and are more likely to have poor nutrition than city populations.

Hospital admission rates for remote populations are higher than in the city, with 1.5 to 1.8 times the rate of metropolitan populations. Factors that contribute to this may be distance from hospital or a greater incidence of accidents (farm and manual labour injury)—the true reason is unclear.

Death rates are 10 to 20 per cent higher in rural and regional areas than in metropolitan areas. This statistic, alarming in its own right, is mainly a result of increased overall Indigenous death rates, which are very high compared to those in metropolitan areas of Australia. The Indigenous median age is 20 years, whereas the Australian population median age is 34 years. The average life expectancy of the Indigenous population is 19 to 20 years lower than the rest of the population, with 2003 census data showing Indigenous males on average dying at 56 years, compared with the national average of 76 years. Indigenous females die at an average of 63 years, compared with the national average of 82 years (Australian Bureau of Statistics 2006). Indigenous populations are four times more likely to have type 2 diabetes, and have greater levels of respiratory and heart disease. They are more likely to have physical injury or suffer poisoning, and have a greater incidence of digestive disorders, kidney disease and renal failure. They also have a higher percentage of mental and behavioural disorders. We can clearly see that Australian Indigenous populations suffer a much greater health risk than metropolitan-based populations.

THINK AND LINK

Working in Indigenous communities can be a large part of fieldwork placement if your placement is in a rural or remote area. Chapter 23 is about working in Indigenous communities, and what you need to prepare for and understand when working in an environment that may be culturally different from your own. The second half of Chapter 14 also discusses working with people who come from backgrounds different from your own.

Who cares for the rural and remote communities?

Another aspect of rural and remote settings is the number of health professionals per head of the population.

Table 22.1 is a snapshot of the ratio of health professionals to populations in rural and remote areas compared with metropolitan areas in Australia. The information in this table and below is based on data from the Australian Institute of Health and Welfare (2002).

The good news is that some health professions show greater numbers in rural and remote areas compared with metropolitan areas. Community Health Service workers in metropolitan areas are 216:100,000, compared with 320:100,000 in remote areas. Ambulance services are generally better in regional and remote areas, with a ratio of 54:100,000 compared with 36:100,000. However, in very remote communities this decreases to 31:100,000.

The other significant factor is that distance is the major obstacle, with perhaps 100,000 people being spread very thinly across remote areas, with hundreds of kilometres between centres.

Table 22.1: Ratio of health professionals to population

	Ratio metropolitan areas	Ratio rural/remote areas
Non-psychiatric hospital health workers	1147:100,000	601:100,000
Nursing home staff	334:100,000	71:100,000
General practitioners	351:100,000	109:100,000
Specialist medical services	93:100,000	11:100,000
Optometrists	53:100,000	1.7:100,000
Physiotherapists	48:100,000	7.2:100,000
Child care services	311:100,000	199:100,000

Source: Australian Institute of Health and Welfare 2002

What does this all mean for rural populations? We have in broad terms a sicker, less educated population with poorer nutrition. This means that what works in the city may not be applicable in rural and remote conditions. There are fewer specialised rural health professionals, although they may have a broader set of generic skills than their urban-based colleagues. Despite having multiple skilled workers in rural and remote centres, access to health services is diminished, and we need to persuade more health professionals to move to rural and remote positions to improve the health of these populations. What this means for health students is that access to your particular discipline may not be possible. There may be blurring of roles; for example, activities considered the domain of podiatrists are undertaken by physiotherapists and vice versa and the nurse or allied health worker will be multiskilled to deal with basic care.

PREPARING FOR RURAL PLACEMENT

The better prepared you are, the more you will gain from your fieldwork placement. Obtain background information from a number of sources to see which Indigenous group you will meet in your fieldwork placement, and the cultural differences and current clinical themes most commonly seen in the area. Is the Indigenous population matrilineal or patrilineal? Which tribe or clan is predominant in the area you are about to work in? Ensure that you are culturally prepared by reading a relevant text about the group you are about to meet. If you know of another student who has worked in this area before, talk with him or her: how did that student prepare? What advice can he or she offer you?

Consider the type and level of practice you will be expected to work in, and the background your fieldwork educators have. Are you working with a fieldwork educator who comes from the same discipline as you, or from another discipline but within a multidisciplinary team? In many remote areas you may find that there is only a general health worker (possibly an Indigenous health worker), and no one from your discipline to lead and direct you, so

you must be clear what it is you want to get out of the placement. Some flexibility will be expected, as often it's 'all hands on deck'. Have a clear understanding of why you are there.

It is also critical that you have a clear idea of the objectives of the fieldwork placement. Is it purely observational? Are you supposed to be learning a practical skill and become competent at it, or will you be working at a novice level? While 'all hands on deck' is a common cry do you have the competencies required to do the task; if not, can you be trained onsite?

THINK AND LINK

Health workers in Indigenous communities have a complex role to play in their community. Chapter 23 explains the health system within Indigenous communities and the roles of the workers within these communities.

FIND OUT FIRST

Some critical issues you must address in preparation:

- What are the uniform requirements of the fieldwork placement? Should you be in a uniform? What does the university require of you? What does the placement require of you? Do you understand the placement standards? (Are there any?) Ask your fieldwork educator.
- How will your performance be assessed while on fieldwork placement? Is this a competency-based assessment? How do you meet the competency?
- How many hours are you expected to be engaged in the fieldwork placement? Often in remote situations you can have a feeling that you should be engaged all the time. Is this realistic, expected and appropriate?
- What are the start and finish dates for the fieldwork placement? Is travel time included? Who is providing the transport? Is it your responsibility to get to the rural centre and then be transported out to the remote centre? Is there a road trip or a flight on a transport plane?
- Do you need a driver's licence?
- What time do you need to start on day one?
- Can you confirm your **accommodation**? What type? What cost is the room, dormitory or tent?
- Where do you get food and drinks while on fieldwork placement?
- What are you going to do in the evenings: read a good book, listen to an iPod, play computer games or DVDs?
- What are the options for playing your sport? Many young people view their sport as a major part of their life. Can you still participate to a greater or lesser extent? Is it safe to do so?
- Will you be involved with the flying doctor service?

PROFESSIONAL BEHAVIOUR AND SURVIVING

Your **professional standards and image** will form an important part of how you will be evaluated by your fellow health professionals and others. First impressions do count, so your enthusiasm and flexibility for your fieldwork placement will be paramount. Your knowledge base should be of the correct standard. Saying 'I'm sorry I do not know' is just as important as having all the right answers. Remember that health theory and concepts often have a twenty-five-year life span, so current clinical thinking may not be well accepted by long-standing health professionals, or may not be appropriate to the situation you are in. How you manage this may well have an impact on your enjoyment of your fieldwork placement. Be aware that even though your first impression might be 'I would not do it like that!', the ability to use critical thinking within the environment in which the healthcare is being provided may be of much greater significance overall than best practice.

Issues of access, health and nutrition are all compromised in rural and remote environments. As a health professional, you may have to struggle long and hard to reach an effective compromise with your patients. Do not be too hasty with any criticism you have of techniques and protocols used by local practitioners, as you may not be aware of the history of practice. Remember that communication is the key: ask 'Why do you do it like that?' For support, you may need to stay in contact with your university placement officer, who may be able to advise you how to proceed in difficult situations.

Getting to know the team and the professional hierarchy is important. As a student, you are often way down the list in terms of role. Know who is in charge formally and informally: perhaps the reception staff or Indigenous health worker have a clearer understanding of the way the centre functions than the fly-in, fly-out specialist. Without local knowledge and a close relationship with the local community, remote centres cannot function. For example, often the janitor is also the security guard, the radiographic technician and plaster cast technical person. Show respect to everyone, as everyone is a cog in the complete machine.

SUPERVISOR PROFILE

SARAH RHEINBERGER

Sarah has been working rurally and remotely for more than six years in clinical and supervisory roles. Her professional interests are in both clinical and supervisory areas, including pretend play development, attachment, Indigenous health, clinical supervision and workforce development. She is passionate about rural and remote practice and furthering allied health leadership across the health sector.

1 *Tell us about your role. What does a typical day involve?*
I am a senior occupational therapist within a primary health service in the northwest of Western Australia. This role is 60 per cent clinical with the remaining 40 per cent being split between administration and line management/supervision duties. Occupational therapy in this rural and remote primary health service includes people of all ages from birth to elderly, with and without disabilities, palliative, acute and

chronic conditions and people from culturally and linguistically diverse backgrounds. We provide a variety of services to our clients in the community, as inpatients and outpatients, though as a primary health service our focus is firmly on enabling our communities to have better access to health within their community. Our work with clients may include equipment prescription, splinting and hand therapy, home assessment, discharge planning, advocacy, intervention for developmental concerns, etc. We also cover a large geographical area requiring travel by car and plane.

2 *What are some of the challenges you face as a clinical supervisor?*

In the Pilbara one of the major challenges is the provision of affordable housing for our students which does limit the amount of students we can take. We also find it difficult to predict how many students we can take given our staff tend to be quite transient and it can take a long time to recruit new people. This means that caseloads tend to be very high and this impacts on student supervision.

As a supervisor we are assisting students not only with their clinical and professional skills but also their life and coping skills such as living away from home without friends and family, often in shared accommodation. We have to know what to look for to identify when students are not coping.

3 *What is unique about this setting in terms of student supervision?*

As supervisors we have to be creative in our supervision given our diverse caseloads and the geographical distances we cover. Students often have a higher degree of autonomy in some cases while it can be more restricted in others. Striking a good balance can be difficult.

4 *What clinical skills are important for this setting?*

Knowing the occupational therapy process and how to use it in a variety of settings, knowing a little about a variety of areas, being client or family centred, having good basic counselling or reflective listening skills and interview skills. Basic hand therapy and splinting skills are helpful as is some basic understanding of paediatrics and skill in the area of safety at home. More importantly are skills such as being able to ask for help, taking initiative, self-reflection, problem solving and being resourceful.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*

Fourth year student: Students should have a good understanding of the location they are going to, the distance it is from their home and identify the supports they may need while away. Students should read about the challenges, demographics and health status of the community in which they will be working, primary health and what this may mean for their work as an occupational therapist. Students should read about Aboriginal culture, family centred practice, inter-professional teamwork and community development. They should come prepared with an open mind, be prepared to be flexible, get their hands dirty and try new things.

6 *What are some of the key learning opportunities available to students?*

- Great diversity of clients and needs that will test their professional as well as their clinical skills.
- The opportunity to work and learn from an interprofessional team and experience client-centred practice.

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- The opportunity to travel by plane to reach isolated communities and see how services differ in various locations.
- Learning about primary health and why it is important in these communities, as well as learning how they can contribute to this.
- The opportunity to live and work in the same community, learn how to set personal and professional boundaries and contribute to the community.
- The opportunity to be resourceful and creative with a potentially greater scope than what a metropolitan practicum can offer.

7 *What would you expect from a 4th year student on placement?*

To know the occupational therapy process and have a go at applying it in a variety of settings with a variety of clients.

To know their strengths and limitations so they can demonstrate enough initiative to be semi-independent but also be able to ask for help.

To be able to clinically reason their decisions regarding their choice of assessment and intervention and know how they will evaluate their interventions.

To be respectful and able to act professionally in the workplace and negotiate personal and professional boundaries with some guidance if necessary.

To finish their practicum with greater knowledge of primary health and to see themselves as a resource for clients to achieve the things in life they wish to achieve.

To self-reflect on their practice and seek feedback from colleagues and clients and understand that reflections and feedback are career-long requirements for practice improvement.

8 *What parts of the placement do students usually find challenging? What tips do you have for these students?*

Being so far away from home with no friends or family in a new community with the strains of being on a placement. We ask students to identify their supports at home early and maintain contact with them as well as bringing any concerns or stress to their supervisor during their regular meetings.

Working with such a diverse range of clients both culturally and in terms of their needs challenges students in their clinical and communication skills. Students are encouraged to prepare for this experience through pre-readings and ensuring their knowledge of the OT process.

Travelling to remote communities may require longer days, more flexible service delivery and travel on planes which can be tiring and stressful. Maintaining work–life balance, getting regular exercise, getting enough sleep and again communicating these difficulties with the supervisor are all encouraged.

REFLECTION

A STUDENT'S REFLECTION ON RURAL PLACEMENT IN BROKEN HILL

I have really enjoyed my stay in Broken Hill. I have been exploring, bushwalking in Mutawintji National Park, camel riding and bike riding, and visiting numerous art galleries. My time with the Royal Flying Doctor Service is one I will cherish forever. It is an

experience few get to see, and I loved it!!! The health worker was a fantastic supervisor who guided me to become a better practitioner. I will continue to learn and use the skills she has shared with me. An experience that I will never forget ...

QUESTION

What can a rural fieldwork placement offer that a metropolitan fieldwork placement cannot?

Working towards a particular competency assessment may be the objective of the placement, so what are these competencies and how will they be evaluated? Make sure your fieldwork educator has time to do the required assessments. Sometimes this is difficult, particularly during a crisis, when patient care overrides everything else. Try not to ask for your evaluation at the end of the day when everyone has gone to the pub. Make sure time is set aside for feedback and review of your fieldwork placement competencies.

In rural and remote settings you may work with several health professionals. Ensure you are *very* clear about your scope of practice, and stay within the bounds of your own discipline. You may be able to assist another professional from another health field, but never work independently outside your discipline.

THINK AND LINK

Chapter 7 considers fieldwork placements when you might be supervised by someone outside your discipline-specific area. In these situations you will often need to explain your profession and what your profession does. The same may occur when working in a rural or remote setting.

A positive aspect of this type of placement is that government agencies are currently trying to breach the workforce shortage in rural and remote areas, so you may be eligible for substantial scholarships or grants to assist you with travel and living costs if you undertake a rural or remote placement. Ask your university placement officer for more information about these schemes. You may like it so much that you become a much needed rural practitioner.

ACCOMMODATION AND LEISURE

The lack of 'quality' *accommodation* is often complained about while on fieldwork placement. Look around you. What is the local standard? Maybe your accommodation is the best there is in this particular setting. How much are you paying for it? Is it subsidised? If this is the case, can you really complain? Is it clean, with access to water and sanitation? It may lack air-conditioning and computer access, but it could be the only choice available. Being flexible is the key here.

If you are using shared facilities, ensure that you care for others. Is there a nightshift worker or nurse who is also in the accommodation? Can you really steal 'just a drop' of milk

for your tea from the shared fridge? Many disputes have occurred from taking liberties in shared accommodation. What do you do in the evenings? When you are away from home, the status quo may not be possible; access to a TV may be limited, wireless access for your laptop or even power may be limited; so be flexible. Reading your study text might have seemed a good idea before you went on fieldwork placement, but relaxing with a trashy novel may just be the release you need after a busy day. Whatever you plan to do while you are away you will be lucky to get half of it finished. You may not get that essay written, or those ten chapters reviewed before the end of the fieldwork placement, so keep your aims realistic once onsite.

Enjoy the whole rural experience. Talk to the locals, go along to the dance on Saturday night, do the camel ride or enjoy the rodeo or whatever is on offer. Remember that pub culture is strong in rural communities, be it the football (footie) club bar or town pub. These are often the centre of some social and community functions. Make sure you have control of yourself; you need to maintain your self-control and drink sensibly. Excessive alcohol drinking will dehydrate you the next day, and may make you unfit to see patients. You must be able to function at your best while on fieldwork placement. One less drink is better than one more. For students whose background does not condone alcohol consumption, soft drinks and hot drinks are available at pubs so you can still attend social and community functions without feeling pressured to consume alcohol.

Another important issue is: 'Where do I get food from?' Many fieldwork placements go out of their way to help and assist visiting students, as they want to give you the best experience possible. Often these special considerations have been hard-fought for, so don't complain about what you have been given. Many placement sites in rural and remote centres have extremely limited resources, and food costs can be very high because of transport costs and lack of competition among providers. Basic food items are often two to three times more expensive than in the city. You may well be getting the best available, but not what you are used to. If you have special dietary needs, these must be known ahead of time, as access to specialist food items may not be possible or may be too costly. This may even be the reason some students do not go on placement in remote areas.

Other factors to consider include fatigue from long working days and relative lack of sleep. Hot sun, hot days, hot nights, no sleep, dehydration (alcohol induced or otherwise) or acclimatisation issues will all add to your fatigue. Even small trips away can give you travel lag or jet lag. All these factors may take a toll on you and will affect your performance. Recognise your limitations: go to bed when *you* need to. Do not compromise yourself.

SUPERVISOR PROFILE

ALISON BRUCE

Alison received a Bachelor of Speech and Language Therapy at the University of Canterbury, New Zealand, in 2004. She has been working in the Pilbara, in Karratha for over three years and has been acting in the senior role for eighteen months. Her clinical interests include family-centred practice, early intervention, parent-child relationship, imaginary play, relationship based therapy, augmentative and alternative communication

and speech sound disorders. Her experience in a senior role has made her realise how difficult, but how integral, professional supervision is to the lifelong learning experiences of speech pathologists.

1 *Tell us about your role. What does a typical day involve?*

I work for Pilbara Population Health–West in the Northern Country Health Service in Western Australia. I am currently the Acting Senior Speech Pathologist, with a staff of two speech pathologists and one allied health assistant. A typical day for me includes:

- working face to face with clients including some outreach and planning and preparing for assessments and interventions, supporting the staff I line manage with their duties and professional development
- liaising with teachers, parents and other stakeholders regarding children being referred or children on the wait list
- liaising with other staff and senior staff regarding projects or happenings in the workplace
- completing reporting requirements and updating statistics and client databases
- chairing or assisting with recruitment of staff, participating in primary health events and planning for events
- attending/chairing interagency and staff meetings, and attending professional development events.

We are considered a generalist service, servicing everyone from birth to death who requires our service. Our caseload is primarily paediatric with early intervention being a high priority. As we are in a remote location we also have many Aboriginal clients. Our service also incorporates some driving and flying to outlying towns and communities.

2 *What are some of the challenges you face as a clinical supervisor?*

The single biggest challenge is my ability to juggle all the tasks that I have to and want to do. At times I find it difficult to prioritise my work and complete some of the important but non-urgent tasks. Supervision is one of these important but non-urgent tasks so making time to seek professional development opportunities with regards to supervision can be difficult. It is also difficult to get funding support from my organisation for these opportunities. Encouraging staff and students to be proactive in seeking and receiving their supervision in a variety of formats can be a challenge.

I really do want my students to have a valuable experience and to enjoy the placement on a personal level. I had experienced a placement as a student that did not work out so well, I wouldn't wish that on anyone. It really knocks your confidence.

3 *What is unique about this setting in terms of student supervision?*

The remoteness of the setting means that students are away from the people that usually support their learning and emotional needs. The generalist caseload and the Aboriginal caseload are unique in this setting. Our very inter/transdisciplinary and family-centred way of working leads to students sometimes receiving supervision from other allied health staff and having to open their mind to more than just thinking about speech and language.

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4 *What clinical skills are important for this setting?*
The most important skills for this clinical setting are those that are hardest to learn. Clinical knowledge is not necessary, but you have to know how to seek knowledge and understand how to incorporate this into your work. The ability to look at a client as a whole person and to be able to work alongside other allied health staff and students. Self-awareness, reflective capacity and the ability to make changes from this are extremely important. Sound interpersonal, communication and organisational skills are skills that will make a clinical placement more successful. A student needs to be able to ask for help in the right situation.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*
We send students articles to review and ask them to find another article that supports or negates what we have given them. The articles are chosen to reflect the nature of this workplace and include topics such as working with Aboriginal people, working in a family centred and interdisciplinary way. We also send a slideshow giving information about Karratha and the placement and what to expect. All students should ensure that they read this information.

All students going away for a placement should recognise that being away from home can add an extra element to the placement. Find information on rural and remote practice and arrange to catch up with friends or family over the phone/internet regularly. The National Rural Health Students' Network and the SARRAH website have a wealth of resources and modules on rural and remote practice (see Useful Websites at the end of this chapter).

If it is not provided, ask for information on the caseload and ensure you take all the materials you already have that are appropriate. Ask if there are any particular programs or models of therapy used and ensure you are familiar with these.

6 *What are some of the key learning opportunities available to students?*
The students themselves are their biggest learning tool. We try and encourage students to reflect on their performance and solve their own problems with our support.

Students are able to attend any video conferences that are on offer as long as deemed appropriate by their supervisor. They are also encouraged to seek opportunities to observe and talk to other professionals in the workplace. Our students are taking part in a long-term interdisciplinary project that has been going for a year and a half and so far six different students have contributed.

7 *What parts of the placement could students find challenging? What tips do you have for them?*
It can be very isolating to be away from your normal supports on a remote placement. Before you go, make sure you have a plan for how you will continue to touch base with your supports. Talk to your supervisor if you are struggling to cope with the isolation. Find out if there are community groups that you can join that reflect your interests. Be aware of the nature of small communities. Join the rural and remote student networks and have a look at the SARRAH website.

Arrive at your placement with an open mind. Sometimes the philosophy or culture of a team that you enter can be different to what you expect. Be open about

this with your supervisor and approach this with an investigative mind, and ask questions rather than attempting to argue the point.

Workload increases towards the end of the placement can be difficult; be prepared for this and ask for help if you need it.

Supervisors are human too, and you will meet a large variety in terms of clinical and supervisory skill. If you are not getting what you need, talk to your supervisor about your concern. If they are not responsive then speak to your clinical educator. Ask for a regular catch-up time with your primary supervisor at the start if it is not offered. This can prevent finding at the end of your placement that your supervisor is planning to give you much lower marks than you thought you would get.

8 *What would you expect from a student on placement?*

First year student: I expect that a first year student will spend most of the time observing with some supported client contact. If the placement was towards the end of the year, I would expect them to be able to take a goal that I give them and prepare an activity or to look at the resources available and suggest a possible assessment battery. I would expect them to require a lot of feedback on these tasks.

Second year student: The second year student should be able to increase their direct client contact but I would expect them to be supervised every session or every second session. I would expect them to have less reflective capacity and require a lot of advice and assistance. I would also expect them to need a lot of assistance to prioritise their workload.

Third year student: They should be moving on from the more intense support required by a second year student but not as independent as a fourth year. They would probably need more support to think reflectively.

Fourth year student: I would expect a fourth year student to need initial support that can be faded out through the placement. They should be able to prioritise their work with support. They should be able to seek more support when they need it and not need to wait for the supervisor to initiate contact. They should know what they want from the placement. I like to get them to draw up a diagram of their expectations of the placement, their supervisors and themselves. I expect them to need infrequent direct observation from the supervisor. In five to seven weeks they should be able to manage at least five of their own clients throughout the placement as well as being able to run a school aged screening clinic day, prepare activities and session plans for shared clients (either shared with other students, speech pathologists or other allied health professionals) and extra assessments as required to create their initial caseload. I expect an adequate handover of clients. They should also be able to complete some project work.

ROYAL FLYING DOCTOR SERVICE (RFDS)

The **Royal Flying Doctor Service (RFDS)** is an organisation you could become involved with because of the distances involved on some placements. Remember to minimise the stuff you want to bring. Take only a small bag with your essentials. If you do not like small planes,

take a sick bag and nausea pills. If you really cannot cope with flying in a small aircraft, do not apply for this type of placement. If you cannot fly, you become a liability for those around you, with dehydration and anxiety a real issue in the bush. Staff have enough to do without having to cope with your sickness.

You could easily find that you are 'dumped or dropped' from a flight. Missing out on a trip is unfortunate, but you must remember that you are there at the invitation of the fieldwork placement staff, so emergencies will take priority over your education needs. You need to see the big picture when lives may be at risk.

WHY DO A FIELDWORK PLACEMENT?

Some of you will read this chapter and wonder why they would want to put up with so much change and disruption. Why bother with a rural fieldwork placement? The rewards are there for those with an open mind, a give-it-a-go attitude will give you an experience never to be forgotten and never repeated. The intention of this information is to encourage you to become part of the regional, rural or remote healthcare team in the future. It's not for everyone, but you will *make a difference.*

CASE STUDY

My first week

My first week consisted of working with a number of visiting practitioners. We went up with the Royal Flying Doctor Service twice, once to Ivanhoe and once to White Cliffs. I got to ride in the cockpit both times! They made us homemade scones at White Cliffs. I love country hospitality!

I also went out to a remote centre with a large Aboriginal population. Our clientele was 80 per cent Aboriginal, which was a good cultural experience for me. The diabetes centre provides free care to all patients with diabetes and they do a terrific job. They have excellent, culturally sensitive education and follow-up care, which is maybe why there is a reduction in the problems seen in this population. Many of the clients are high risk, which is directly linked to the high level of obesity and the number of people in the area with diabetes.

For this week and next week my fieldwork educator has returned to Sydney, so I am spending time with different disciplines around the local hospital. I went out with the ambulance officers for a ride on Monday, which was an awesome experience, an intense and rewarding day. I have seen knee replacement surgery and took part in falls classes with the physios, which was really interesting. It has broadened my knowledge of rehabilitation, including muscle building and strengthening before and after surgery.

I also spent a day with the OTs (occupational therapists) and did a house assessment for a patient who they were trying to get home. Very interesting; it involved a lot of measuring and risk analysis. I think that I now understand what OTs do! I will spend my last two weeks with the podiatrist again. I'm off to the Royal Flying Doctor Ball tonight with a bunch of other students. The ball is their major fundraiser for the year. This fieldwork placement has certainly been keeping me busy.

QUESTIONS

1 Do you think the attitude of the student in the case study helped or hindered their experience?

2 Discuss what this student learnt about working in teams.

3 Would this student's experience extend beyond their professional learning? If so, how?

SUMMARY

Undertaking a rural and remote placement can take you out of your comfort zone. You need to prepare well in order to get the most out of your placement. For example, you need to check the time to start and the time spent on placement, transport (how to get there and how you get around when you are there), accommodation, food (particularly if you have special dietary needs) and what you do after work (how you relax and spend your evenings).

You may encounter situations that you have never come across before, and this may be challenging but also extend your professional skills. You will work with a range of health professionals, and may be involved in delivering health services to Aboriginal communities.

Discussion questions

1 Is there anything that would stop you from undertaking a rural and remote placement?

2 Are you prepared to step out of your comfort zone?

3 In a rural setting, you are likely to see a variety of clients or patients. Are you prepared for that?

4 What would you want to get out of your rural and remote fieldwork placement?

Portfolio development exercise: Flying with the RFDS

Imagine you are about to join the flying doctors on one of their outreach services. Your baggage allowance is 5 kg and let's assume 3kg of the 5kg will be needed for basic clothing and toilet items. What would you take and why? But what else? Books? (which ones and why?) your Mobile phone? iPad? USB with your notes? What do you need to find out before you decide what is the most valuable?

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USEFUL WEBSITES

Australian Institute of Health and Welfare (AIHW)—Publications: www.aihw.gov.au/publications

National Rural Health Students' Network: www.rhwa.org.au/site/index/cjm?display=163792

Services for Australian Rural and Remote Allied Health (SARRAH): www.sarrah.org.au/site/index.cfm

CHAPTER 23

Working in Indigenous Health Settings

Deirdre Whitford, Judy Taylor and Kym Thomas

LEARNING OUTCOMES

After reading this chapter you should be able to:

- discuss Indigenous health issues and their determinants
- give a critique of the state of Indigenous health outcomes
- reflect on your own attitudes towards Indigenous culture
- recognise cultural difference and its potential to impact on outcomes of healthcare interactions
- have a knowledge of fieldwork placement at an Indigenous health setting.

KEY TERMS

Aboriginal and Torres Strait Islander (ATSI) people
Aboriginal community-controlled health service
Aboriginal health workers (AHWs)
Determinants of health
Exclusion
Indigenous health
Indigenous health settings
Indigenous population
Multiple language groups

INTRODUCTION

Student fieldwork placements in **Indigenous health settings** aim to increase the capacity of students to improve health outcomes for **Aboriginal and Torres Strait Islander (ATSI) people**,[1] contribute to service delivery and develop partnerships between Indigenous and non-Indigenous organisations, service providers and universities. These aims are of particular importance because the health outcomes for the Aboriginal and Torres Strait Islander population are markedly worse than for the mainstream population (ABS/AIHW 2008).

1 The term 'Indigenous' is used to refer to both Australian Aboriginal and Torres Strait Islander people.

While the Australian healthcare system is recognised globally for its solidarity and quality, in general it has not met the needs of the **Indigenous population** well, particularly in terms of its appropriateness, equity of access and cultural awareness, safety and security. Improving **Indigenous health** requires reducing the complexity of funding arrangements, acknowledging the nature of the contact between Indigenous people and European settlers, and addressing structural power imbalances to increase Indigenous Australians' sense of control over their circumstances (Couzos & Murray 2008).

The social, economic, environmental and biological **determinants of health** differ between cultural groups, and result in differences in context, case mix, care and care delivery needs. These differences are most obvious between Indigenous and non-Indigenous cultures, but they also occur between different Aboriginal and Torres Strait Islander groups.

It is essential that you learn:

- to deliver care differently to different cultural groups to meet their needs equitably and appropriately
- to recognise that working in Indigenous health requires you to work collaboratively across disciplines and sectorial boundaries.

In Indigenous healthcare settings, the health problems encountered are very complex, with ill-defined boundaries and multilayered causal links. Further complexity is added when health services are provided in rural and remote locations and to **multiple language groups**. Aboriginal and Torres Strait Islander people might live in the same location and attend the same health services, but their cultures might be very different. There might be a variety of languages, group histories, beliefs, practices and needs, and while adding diversity to fieldwork placements, this may limit the extent to which you can become immersed in any one particular Aboriginal or Torres Strait Islander culture.

Issues such as **exclusion**, poor education system outcomes, unstable housing, unemployment, relatively high levels of domestic and child abuse, and drug and alcohol abuse have an impact on the health outcomes of many Indigenous Australians (Carson et al. 2007). Many of these risk factors are the responsibility of the wider community; however, Indigenous Australians will continue to require care in the healthcare system until the causes of their poorer health outcomes are addressed.

Chronic diseases account for more than 70 per cent of the gap in Indigenous health outcomes, as outlined in the Prime Ministers Closing the Gap Report (Commonwealth of Australia 2011). They are often preventable and require specialist health treatment. Aboriginal people often need to move from rural and remote areas to seek specialist healthcare in urban areas. It is therefore the responsibility of all health professionals (rural or urban, hospital or community) to provide care to Indigenous Australians in the most effective and appropriate manner possible, and to participate in bringing about social and political change to improve Indigenous health outcomes.

THE CONTEXT OF INDIGENOUS HEALTH

The multicultural Australian population generally enjoys high living standards and health outcomes. The determinants of these health outcomes are debated; however, factors such as the relatively robust economy and high standards of public infrastructure, education, housing and healthcare are recognised contributors.

The Australian Indigenous population does not enjoy the same health or wellbeing outcomes as the population as a whole. The factors affecting Indigenous health and wellbeing are also debated, but are thought to be based in historical, social, language and cultural issues affecting social inclusion. Poor social inclusion touches all aspects of physical and emotional life.

While individual members of the Indigenous population are spread across all strata of the Australian economic, academic, sporting, music, art, business and entrepreneurial scenes, Indigenous people are overrepresented in the lower strata for income stream, education achievement, health and wellbeing measures, unemployment, unstable housing and imprisonment. Some Indigenous individuals are achieving high levels of attainment in politics, law, medicine, science and arts, and enabling change for greater social inclusion of Indigenous people generally. In 2011 there were an estimated 153 Indigenous medical practitioners and 218 Indigenous medical students (Australian Indigenous Doctors' Association 2011).

Indigenous people are diverse in their healthcare needs

Traditional Aboriginal cultures developed over many thousands of years in sympathy with the Australian land. Traditional cultures had well-developed systems for the maintenance of tribal laws, family structures and health and wellbeing. All Indigenous Australians share the history and heritage of the impact of colonisation. Colonisation and invasion of Australia by Europeans in the 1700s led to a period of conflict between the traditional Indigenous owners of the land and the colonisers. Colonial and postcolonial governments denied Indigenous Australians' land ownership and the inherent Indigenous cultural significance of the land, as well as Indigenous citizenship rights. Disastrous experiments with 'assimilation' policies were imposed, including the removal of half-caste children from their Indigenous families ('the stolen generation'), a policy that persisted into the mid-1900s. These actions added to the pain, grief and loss experienced by Aboriginal people as a result of the settlement of Australia by non-Indigenous Australians.

Since the settlement of European populations, generations of Indigenous Australians have experienced social disharmony and dysfunction, marginalisation and disadvantage, loss of culture and identity and lack of social inclusion into the wider Australian population. The impact of this shared history is variable, with the balancing of social life to incorporate cultural components, while living as integral members of the broader Australian society, poses significant challenges for all Indigenous peoples.

Progress has been made to reinstate traditional land ownership and the citizenship rights of Indigenous people within the changing Australian social landscape. 'Sorry Day' (26 May) sees many thousands of mainstream Australians expressing the sorrow these actions caused for the current generation of Australians. The apology to the members of the stolen generation made by Prime Minister Kevin Rudd in 2008 went some way towards repairing the relationship between the Indigenous Australian population and the mainstream Australian population. Much work remains to ensure Indigenous Australians enjoy the benefits of their unique place in Australian society. The challenge is to develop an environment in which Indigenous–mainstream relationships and partnerships can further improve, and in which Indigenous people can retain their connection with their cultural identities, while also enjoying the opportunities available through full participation and inclusion in the wider Australian society and beyond.

INDIGENOUS HEALTH OUTCOMES

Queensland, Western Australia, the Northern Territory and South Australia are the only jurisdictions that have data of sufficient quality to compare health and welfare outcomes for the Indigenous population compared with that of the Australian population as a whole. In July 2009, Prime Minister Kevin Rudd acknowledged that statistics on Indigenous Australians were inadequate, and gave a commitment to the task of collating accurate statistics.

The health status of Indigenous Australians had shown little improvement in recent years, and remained considerably below that of non-Indigenous Australians (www.aihw.gov.au/indigenous-health):

- Indigenous adults were twice as likely as non-Indigenous adults to report their health as fair or poor.
- Hospitalisation rates were higher for Indigenous Australians, particularly for conditions that are potentially preventable, such as type 2 diabetes and kidney disease.
- The mortality rates of Indigenous people in 2001–2005 were almost three times the rate for non-Indigenous people in Queensland, Western Australia, South Australia and the Northern Territory.

Findings from the most recent report on Aboriginal and Torres Strait Islander health and welfare outcomes (Australian Bureau of Statistics/Australian Institute of Health and Welfare 2008) include:

- Indigenous people were half as likely to complete Year 12 as non-Indigenous people
- Indigenous adults were more than twice as likely as non-Indigenous adults to smoke regularly
- more than half of Indigenous people were overweight or obese
- Indigenous people face barriers in accessing health services, in particular primary healthcare.

REFLECTION

1. What factors contribute to poorer health outcomes for Indigenous Australians?
2. What could your health profession do to improve health outcomes for Indigenous Australians?

INDIGENOUS HEALTH STRATEGIES

In order to overcome health disparities between Indigenous peoples and Australians as a whole, state and federal governments have put in place national targets. These health targets are contained in the 'Close the Gap' targets set by COAG at the National Indigenous Health Equality Summit in March 2008 (www.hreoc.gov.au/social_Justice/health/targets/index.html). A section of the summit targets outline is:

> The Council of Australian Governments has agreed to a partnership between all levels of government to work with Indigenous Australian communities to achieve the target of closing the gap on Indigenous disadvantage. COAG committed to:
>
> › closing the life expectancy gap within a generation;
> › halving the mortality gap for children under five within a decade; and
> › halving the gap in reading, writing and numeracy within a decade.
>
> The aim of these targets is to achieve the three COAG goals, and particularly the two health goals. Hence they address:
>
> › the main components of excess child mortality—low birth weight, respiratory and other infections, and injuries;
> › the main components of life expectancy gap—chronic disease (cardiovascular disease (CVD), renal, diabetes), injuries and respiratory infections account for 75% of the gap. CVD is the largest component and a major driver of the life expectancy gap (~1/3); and
> › mental health and social and emotional wellbeing, which are central to the achievement of better health.

In the Department of Health and Ageing 2008 Budget Papers, Indigenous health outcomes are stated as:

> The Australian Government is committed to closing the 17-year gap in life expectancy between Indigenous and non-Indigenous Australians within a generation, and to halving the gap in mortality rates between Indigenous and non-Indigenous children within a decade. Through Outcome 8, the Government aims to ensure that Aboriginal and Torres Strait Islander people have access to healthcare services essential to improving health and life expectancy. The Government aims to achieve this outcome by working in partnership with Aboriginal and Torres Strait Islander people and organisations, and through collaboration with State and Territory governments. (2008: 135)

The key strategic directions in Indigenous health are listed as:

› improving access to effective primary healthcare, substance use and social and emotional wellbeing services for Aboriginal and Torres Strait Islander people
› improving child and maternal health
› working with other governments and the broader health sector to improve health outcomes for Aboriginal and Torres Strait Islander people.

The Prime Ministers Closing the Gap Report (Commonwealth of Australia 2011) indicates some improvements; decreased mortality rate; gains in life expectancy; educational achievement; employment and housing; but much work still required to meet the targets of 2020.

INDIGENOUS HEALTH WORKFORCE

In 2006, it was reported in the *Medical Journal of Australia* that 34 per cent of the Australian population lived outside major cities, along with 70 per cent of the Indigenous population. The percentage of health professionals who lived outside urban areas represented a shortfall

at 23 per cent of medical specialists, 27 per cent of general practitioners, 34 per cent of nurses and 25 per cent of physiotherapists. The extended roles of these health professionals, as well as the unpredictability of their availability to the Aboriginal and Torres Strait Islander (ATSI) population, were also noted (Murray & Wronski 2006).

Murray and Wronski (2006) noted that rural student fieldwork placements were effective in increasing the rural workforce. It is likely that these findings are generalisable to the Indigenous healthcare setting, and that positive student fieldwork experiences in Indigenous health will provide the same success in recruitment to Indigenous health professional careers. There is also a need for the extension of roles, particularly those of **Aboriginal health workers (AHWs)**, through supervised delegation, improved Indigenous entry to health professional programs and improved training and recognition of AHWs (Murray & Wronski 2006).

Development of the role and training of AHWs was a strategy to improve access to healthcare for Indigenous people, particularly in remote areas. However, the designation of the title AHW includes people with no clinical training, as well as those providing advanced clinical care in emerging areas of need such as haemodialysis and midwifery. National competency standards have been developed and now need to be incorporated into human resourcing processes and education pathways.

In spite of favourable selection processes, small, but increasing, numbers of Indigenous people gain university places in health professional training courses. The underlying cause is educational disadvantage as a result of isolation, remoteness, poverty and negative primary and secondary school experiences resulting in poor literacy achievement (Adams et al. 2005). In the short term, meeting the workforce needs of Indigenous people cannot be achieved through the training of Indigenous healthcare professionals. Current strategies indicate the need for widespread training of non-Indigenous healthcare professionals in Indigenous health and cultural issues to improve Indigenous health outcomes and the appropriateness and effectiveness of healthcare delivery. The Indigenous Allied Health Australia Network has also been established to encourage and support Indigenous Australians to take up an allied health profession.

SUPERVISOR PROFILE

JANELLE CLIFTON

Janelle is a part-time occupational therapist with Pilbara Population Health. She has worked in rural and remote Western Australia for ten years and loves the variety that working in a country area provides. With Pilbara Population Health, she worked with the whole continuum of care with clients of all ages. She particularly enjoys remote visits to Indigenous communities, and loves to see the vast Pilbara from the window of a light aircraft as she comes into a remote community and to meet the people who have such strong links to the land and to each other.

1 *Tell us about your role. What does a typical day involve?*
As an occupational therapist in a rural/remote setting, a typical day could mean seeing a young adult with a hand injury first thing, then going out on a visit to check safety for an elderly lady at risk of falls in her home, and then finally seeing a two-year-old boy with developmental delay in the afternoon.

I work in a regional health centre that services a town population of over 20,000 people, plus outlying towns as well as remotely servicing several smaller Indigenous communities across the regions. To give an idea of the geographical distances, the entire region covered is around 380,000km^2, or roughly the size of Norway. The three person Occupational Therapy Department provides inpatient and outpatient services, primary (community) health services and services to people with disabilities across all age ranges. Clients may be seen as inpatients on the hospital ward, in a clinic setting, in their homes or at a remote clinic.

2 *What are some of the challenges you face as a clinical supervisor?*
- Linking practice to theory in a wide range of clinical settings.
- Introducing students to culturally sensitive ways of communicating that are positive for both clients and student.

3 *What is unique about this setting in terms of student supervision?*
Apart from having to assess and treat more than one client group, the students are often supervised by more than one therapist. This means more coordination is needed on behalf of the supervisors, but it gives the student a chance to learn the different styles and approaches of the different therapists.

Also in a smaller community, most often away from home, the student's contact with those at work rarely ends at the end of the work day. Students are often invited to join social events and on longer remote visits they may have to stay overnight in the communities along with the therapist. This can have advantages and disadvantages. A stronger sense of team can be built by socialising with those you work with. However, we all need a break and sometimes work/home life separation can be blurred.

4 *What clinical skills are important for this setting?*
Students need to have a firm grasp on a range of basic assessment tools, both standardised and non-standardised. Many different treatment modalities and techniques will be used throughout the practicum, so it is good to know a few basics; however this will be built on while on fieldwork.

Looking at the client as a whole, really listening to what they want for their goals, while thinking about their story and situation will help to provide a more holistic, client-centred and effective service. The ability to think laterally and to be flexible in approaches adds to the effectiveness.

A high level of verbal communication skills are essential as the student will often need to collaborate with other team members, both in and outside of the organisation, in order to meet the needs of the client. Over the phone follow-up is a large part of the service for remote clients.

Self-reflection and self-evaluation are the most important skills of a clinician in a rural/remote setting. Students need to know their limits when it comes to knowledge

and skill. It is okay not to know everything—you never will with such a diverse range of clients—however, you need to know when and where to seek further professional advice when it is required.

5 *What preparation is expected or of benefit to students prior to commencing a placement in this setting? What literature or resources should students review?*

Third and 4th year students: To prepare, students should contact their supervising therapist. Fieldwork can be quite different from one student to the next depending on what programs currently have priority, what services have been chosen at the time for the student to cover and whether or not the student will join therapists on remote visits. Students should be familiar with theoretical frameworks to base their practice on as well as a range of 'bread and butter' assessment and treatment approaches. Again, ask the supervisor. Literature on multidisciplinary teamwork and primary health theory are useful as these are not always covered in undergraduate courses but are a part of day-to-day practice in this setting. Be prepared to spend some time on weekends once on practicum reviewing information like local Indigenous culture and language.

6 *What are some of the key learning opportunities available to students?*

In addition to working alongside more than one supervisor, the multidisciplinary team works quite closely across most client groups, especially when conducting remote visits. It is a fantastic opportunity to gain skills from other therapists and also to experience great teamwork where professional boundaries are respected, but not overprotected.

Onsite education sessions are often conducted via videoconferencing facilities from the metro area and students are always encouraged to attend these professional development opportunities.

7 *What would you expect from a 3rd year or 4th year student on placement?*

Third year student: Ask a lot of questions! If the student is not sure of who to ask about clients, resources, etc ask the supervisor. Always speak up about what they want to get out of the fieldwork and if they are not sure what is expected of them.

Fourth year student: Still ask a lot of questions. Better interpersonal and communication skills would be expected at this stage as the student moves towards becoming a therapist in a team environment where distance is often a barrier to effective communication.

8 *What parts of the placement could students find challenging? What tips do you have for them?*

One of the most common challenges would be communicating with Aboriginal and Torres Strait Islander clients. The cultural differences take time to learn and overcome. Take your cues from the therapist, approach clients in a respectful way that is quiet at first. Many of these clients are shy or wary of people from government institutions and time is needed to establish effective relationships. If there is access to an Aboriginal Liaison Officer through the workplace, take the opportunity to meet this person as it is the best way to learn culture-specific information to the area and to be linked to a trustworthy person to build your own therapeutic relationships.

STUDENT FIELDWORK PLACEMENTS IN ABORIGINAL HEALTH SETTINGS

Placement settings

Aboriginal community-controlled health services

An **Aboriginal community-controlled health service** is a primary healthcare service designed to deliver holistic, comprehensive and locally appropriate primary healthcare. While services differ markedly with regards to governance, extent of service delivery and availability of different types of health professionals, they are controlled by the local Aboriginal community via an elected board of management. Although referred to as Aboriginal community-controlled health services, the term is understood to include both Aboriginal and Torres Strait Islander people. There is an established network of over 140 services in every state and territory. The National Aboriginal Community Controlled Health Organisation (NACCHO) provides a national voice and mandate to speak on health issues for Aboriginal communities throughout Australia.

The services use a holistic understanding of health which includes the social, emotional and cultural wellbeing of the whole community so that each individual is able to achieve their full potential as a human being and this, in turn, feeds into the wellbeing of the community. It is a whole-of-life view and includes the cyclical concept of life-death-life (National Community Controlled Health Organisation).

As many Indigenous health fieldwork placements take place in an Aboriginal community-controlled health service, it is important to understand the differences between Aboriginal-controlled and mainstream health services. Most importantly, Aboriginal community-controlled health services are a living embodiment of the aspirations of Aboriginal communities and their struggle for self-determination (see NACCHO at www.naccho.org.au). They have come about because of strong community interest in improving health, and as an alternative to mainstream health services, which for various reasons have been, and to some extent still are, inaccessible or inappropriate for Aboriginal and Torres Strait Islander people.

Aboriginal health services are highly participative, having been built through community control and community participation, particularly in their establishment (Couzos & Murray 2008). Participation occurs in board membership, through the process of defining needs and priorities, and by providing feedback about service delivery. The health service usually plays an important role in the community, and therefore has a knowledge base about Indigenous affairs and an infrastructure from which to develop programs and services. Because of the holistic nature of service delivery, and because Aboriginal health services are community controlled, they are an effective platform for the community to develop related initiatives to promote socio-emotional wellbeing. Often, Indigenous staff working in these organisations take leadership positions in planning and advising governments and other agencies on Indigenous health and wellbeing issues.

Because the organisations have a cultural orientation, it is inevitable that there is overlap between organisational and social and family affairs as part of health service delivery. This is usually considered a strength, leading to an in-depth understanding of how programs need to be developed in order to make them accessible for those who most need to use

them. However, community obligations and responsibilities from time to time may come into conflict with, as well as complement, the functions that the organisation performs in delivering services. There are always challenges in balancing sectional interests and family and organisational demands, and Aboriginal and Torres Strait Islander health managers use high-level management skills.

Aboriginal-controlled health services may vary in their attitudes towards having students on fieldwork placement. Most Aboriginal community-controlled health services would regard you (the student or tutor) as a potential Indigenous health advocate, and work to provide you with opportunities to gain effective cross-cultural skills. Placements may result in significant changes in attitudes about Indigenous health leading to improved Indigenous health and patient outcomes.

THINK AND LINK

Rural and remote settings can provide an interesting and challenging experience for your fieldwork placement. Chapter 22 discusses how to prepare for these settings, and provides other useful information to consider.

Other Indigenous health settings

You may be placed in healthcare settings that are not community controlled. These placements may include Indigenous health units within tertiary hospitals, or field trips to health services within Aboriginal communities. In an Indigenous health setting in a tertiary hospital you will learn about the difficulties of providing care to Indigenous people who are far from home and in a hospital with a predominantly Western culture. Your placement will provide you with the background that you will need to provide appropriate care. You may also be placed in non-health settings, such as a community centre; however, the learning objectives will generally be health related. On occasions you may have an opportunity to visit an Aboriginal community and learn about how people understand health and illness and the community action that is going on to address health issues.

REFLECTION

1. Aboriginal Australians have a holistic view of health involving their relationship with their land and community. How does this differ from your own view of health?
2. How would you anticipate that an Aboriginal Australian who felt well and had good community connections would perceive a diagnosis of illness based on a pathology test result?
3. Why is respect the most important element in cross-cultural communication?
4. Why is cultural safety in Aboriginal health services very important in improving Aboriginal Australian health outcomes?
5. How can students on placement have an impact on Indigenous health outcomes?

6 In groups find and describe a health initiative developed by an Aboriginal or Torres Strait Islander organisation or community. Compare the health and cultural drivers for this initiative with those of an initiative developed by a mainstream health organisation.

CASE STUDY

Nancy and Geoff

Nancy and Geoff undertook an occupational therapy placement in a small regional Indigenous school where, among the 200-plus students, there was only one non-Indigenous student: the son of one of the teachers. The school was proactive in encouraging students' attendance and participation, providing buses to collect children from wherever they were spending the night, provided that the school was notified during the previous day. Attendance varied between 85 and 95 per cent on most days, and children were given awards for attendance at school. The learning objective for Nancy and Geoff was to create a do-able intervention to address at least one of the determinants of ill health in this population of Indigenous children.

Geoff and Nancy noted that the children did not always have adequate food provided for them at lunchtime: inadequate in terms of quantity as well as nutritional value. Nancy and Geoff decided to address the issues involved in the children's lunchtime nutrition. They noted that interventions that had previously been used in non-Indigenous schools to improve lunchtime nutrition had focused on education programs for parents. In this case, Geoff and Nancy decided to focus on educating the parents about nutrition through the students themselves.

Nancy and Geoff devised a series of lessons in food preparation, value and handling for the children, with a focus on food suitable for lunchboxes. The children also wrote a play about good lunches, and practised the play during the term, as well as making some large collage posters about good lunches in their art lessons. At the end of term the parents were invited to the school to see the play and the posters, and to have a healthy packed lunch prepared by the children.

The short-term outcomes for Nancy and Geoff, the children and the parents were evident on the day, so the school decided to include these activities in the curriculum.

An unforeseen outcome was that a number of Indigenous students began to ask questions about how they could study occupational therapy in the future. In turn, this highlighted a problem where students leaving the school to attend the local high school were not finishing Year 12 because the same support was not available to them at the local high school. Vocational Education and Training (VET) opportunities were not available as an alternative pathway for Indigenous students interested in taking up health-related careers. These observations led to a local collaboration between the schools and the TAFE sector.

This student placement provided Nancy and Geoff with a feeling that they could have an impact on Indigenous health, and they reported high levels of satisfaction with the placement. The school has since continued to seek to have students on placement.

QUESTIONS

1 How many Indigenous Australians are enrolled in your course?

2 What might you have done if you were Nancy or Geoff?

3 How did Nancy and Geoff's project indirectly influence local policies?

Guiding principles for field placements in Indigenous healthcare settings

The Australian Rural Health Education Network (2008), the peak body of the University Departments of Rural Health (UDRH), promotes principles that should guide student placements in Indigenous healthcare settings:

- student placements within Indigenous organisations need to be seen as a privilege and not a right
- universities and their students should assist and support Indigenous communities towards self-determination of local health priorities and planning to address them
- cultural protocol training sessions should be provided for students before they go into communities or Indigenous health settings
- universities and their students should strive to ensure Indigenous issues are acknowledged and acted upon in the forefront of the national and state health agendas
- students on field placements should work with Aboriginal Health Workers wherever possible
- there should be separate debriefing sessions with students and communities at the end of the placement
- it needs to be acknowledged that each Indigenous community is unique and diverse, therefore what is appropriate in one area may not be appropriate in another.

CURRICULUM AND LEARNING OBJECTIVES FOR STUDENT PLACEMENTS IN INDIGENOUS SETTINGS

You will discover that the learning objectives of student fieldwork placements in Indigenous health settings are wide-ranging. They include practical and conceptual preparation for providing culturally safe and effective care to Indigenous patients in all healthcare settings, including mainstream and Indigenous healthcare settings.

These objectives are best served by a broad curriculum encompassing:

- public health, including the social determinants of health (Baum 2002)
- epidemiology: the incidence and prevalence of risk factors and disease in Indigenous populations
- Indigenous people's histories
- discipline-specific skills, including cross-cultural consultation skills
- evidence-based care in Indigenous health (Couzos & Murray 1999)

- social determinants of Indigenous health and their impact on care delivery (Carson et al. 2007)
- personal and professional development, including capacity for self-awareness and reflection on practice
- immersion in delivery settings and service delivery, including frequent patient and supervisor feedback and mentoring
- understanding Aboriginal and Torres Strait Islander community life (Taylor et al. 2008).

REFLECTION

You are about to embark on your first Indigenous health fieldwork placement. Reflect on what you know about Indigenous health and cultural practices, and your attitude to Indigenous Australians.

Personal development

You will find it helpful to reflect on the attitudes you have developed over your lifetime to all minority and marginalised groups, including Australia's Indigenous people. In doing this, you need to develop an awareness of what you bring to your interactions with Indigenous people, and how what you bring influences the outcomes of your interactions. Your effectiveness as a health professional in Indigenous healthcare will depend on your capacity to develop and engender trust and mutual respect with the Indigenous patients you treat.

The context of all cross-cultural interactions is multilayered, and includes historical, cultural and spiritual differences and mismatches. These mismatches affect all aspects of verbal and non-verbal communication within the interaction, and can have a serious impact on the desired outcomes of the interaction.

While academic teaching around cultural differences, historical events and context raise your awareness of Indigenous health issues, immersion in the Indigenous healthcare setting provides richness of understanding, as indicated by these comments from students following fieldwork placements in an Indigenous community setting.

> 'Getting the opportunity to speak to the native inhabitants of the Coorong region was moving—and having their struggle from a first-hand personal account …'

> 'I am more interested in working with Indigenous people after this week. Definitely got me thinking about Indigenous health issues and understanding that everyone is responsible and needs to start doing something … will definitely now try to raise awareness and look into future Indigenous placements and ways to make some sort of difference.'

> 'Made me realise that there is much to learn about Indigenous culture if you were to work in a career with such interactions. It has helped me realise how important such understanding is for them. I would be motivated to learn about appropriate and significant issues before considering myself fit to pursue such a career.'

> 'I never knew that people could be living in such conditions so close to a major centre.'

'I didn't realise the impacts of grief and loss, and how close the bond was between extended families.'

'I didn't know there was so much nitpicking and racist attitude.'

'I hadn't looked at Australia's history through others' eyes.'

With even these beginning understandings, students are more able to contribute to improving Indigenous health outcomes: the ultimate aim of student placements in Indigenous healthcare settings.

WHAT HAPPENS ON PLACEMENT IN AN INDIGENOUS HEALTH SETTING?

Some Aboriginal-controlled health services provide healthcare to many different Aboriginal language and 'first nation' groups.[2] Each of these groups has their own cultural protocols. In your placement setting you will usually be assigned an Aboriginal or Torres Strait Islander mentor, and undertake cultural awareness training to learn the showing of respect, tolerance of being corrected, overcoming language obstacles, male–female protocols, relating information to a third party in a consultation, how the communities served will read body language, getting used to what is considered humorous, personal space issues, and being questioned about your background, marital status and other personal details.

You can contribute in many practical ways to Indigenous health outcomes at the time of the placement. If you are in the earlier years of your course, you can undertake clinical audits, pharmacy reviews, health promotion projects and health checks, as appropriate to your discipline. If you are more experienced, you can undertake history and examinations, community projects and commencement of supervised practice.

You will need to be prepared for the increased complexities of the underlying causes of the presentations to an Indigenous health service, including housing, poverty and social and emotional wellbeing issues. You also need to understand that clients may present late (or even at a critical stage in a disease process), as a result of access issues and different health beliefs.

Even though each university has different learning objectives, you will need to embrace a multidisciplinary—preferably an interdisciplinary—approach to your learning.

THINK AND LINK

Chapter 8 considers fieldwork placements where you spend your time with students from a different discipline to your own. Working in Indigenous health settings requires you to take a multidisciplinary or interdisciplinary approach. Chapter 8 will guide you through what would be involved when working with students from other disciplines.

2 The term 'first nation' refers to all the communities that make up Australian Aboriginal and Torres Strait peoples.

You should also be aware that the Aboriginal health service is granting a privilege to you to learn within the service. It is strongly advised that you are provided with preparatory teaching to develop cultural awareness for the geographic areas and predominant Indigenous language group(s) of that area. Preparatory work might also include instruction in the history of European settlement and the impact of European settlement on Indigenous people; the history of the health service and how it contributes to Indigenous health; the predominant health risk factors and healthcare needs of the health service's catchment area; and how the healthcare service differs from a mainstream service. The health service may provide outreach to many Aboriginal communities over a wide area; be prepared for the long distances to be travelled, and learn basic rural/remote survival strategies.

You also need preparation for the possible impact of fieldwork placement, in terms of having your family or fellow students failing to understand the changes you have undergone or the experiences you have had while on placement. As for all fieldwork placements, you need to be provided with appropriate counselling services for support in the rare event of a traumatic experience.

Field trips

On field trips to an Aboriginal community you will be exposed to local culture and health-related issues such as the distances that need to be covered by the inhabitants of these communities to access services in large centres; living conditions; and lack of access to support services such as pharmacies, and primary healthcare in general, within Aboriginal communities. Field trips provide an opportunity for you to develop skills and knowledge, and acquire cultural understanding, relevant to working with Aboriginal people in varied locations and environments. They also promote more effective ways for you and the professionals and agencies working within health to initiate contacts with individuals, communities and organisations to develop and enhance programs, research activities and collaborative activities. This knowledge will assist you to provide appropriate care and discharge arrangements for Indigenous people. Field trips also inspire and assist you to advocate for change on behalf of Indigenous people, and provide the exposure that will influence your decision-making. You have the opportunity to interact with Aboriginal people, witness environments and social determinants that play a vital role in the health status of Aboriginal people and delivery of health services. Field trips also allow Aboriginal health workers to share knowledge about health issues, unwritten cultural protocols and community concerns. Field trips expose the relationship between ill health and direct causative and underlying factors. Also, social and economic factors need to be acknowledged, and are non-negotiable in understanding the health of Aboriginal people. Field trips highlight the negative consequences of colonisation, but also highlight the unique resilience of the Aboriginal people.

Some quotes from participants:

> 'Seeing the situation firsthand in communities has made it all real for me, instead of just media reports or lectures or readings.'

> 'I liked the way that we were shown things and told about how things worked and were given time to digest that and think on it. It was a safe environment to ask questions and think through things.'

> 'Meeting Anangu people in their country on the … field trip truly deepened my understanding of Anangu culture. I feel the trip was a first step on a long journey from knowledge towards understanding in working with Aboriginal people. For example, while I knew, in theory, that people living on the Lands have little access to public transport, I really didn't understand what that meant until I stood in the dirt by the side of the highway, in complete isolation, 100s of kilometres from the next roadhouse or community, at a derelict tin shed with its roof torn off, and learned that was the bus stop where students would catch a bus to Adelaide or Port Augusta, or where patients discharged from hospital would be dropped off. Hearing it is one thing, standing there and feeling the isolation and destitution is something else completely.'

SUCCESS IN YOUR PLACEMENT

Success in assessment of your performance during the fieldwork placement will generally reflect that you have grasped the principles of working with Aboriginal and Torres Strait Islander people and families: you now understand how Aboriginal health services work and what makes them successful in improving Aboriginal and Torres Strait Islander health; how to participate successfully in providing health services, education, research and/or project work, and about advocacy and influencing policy.

Research has demonstrated the benefits of rural and community-based education (Gibbs 2004; Worley et al. 2004). It is likely that these findings are generalisable to health professional education in Indigenous rural and community health settings. Student feedback from placements in Indigenous health settings demonstrates improved knowledge of health issues and Indigenous health services, awareness of gaps and development of positive attitudes and advocacy intentions. Students report that they feel they were able to make a real difference to the lives of Indigenous Australians, and that they have 'learnt a lot':

> 'Personally, it wasn't until I spent time at – that I was able to see firsthand many of the problems as well as some of the programs used to target and improve quality of life in Indigenous communities.'

SUPPORT FOR STUDENT PLACEMENTS IN INDIGENOUS HEALTH SETTINGS

In order to encourage students in the health professions to undertake rural placements, the Department of Health and Ageing (DoHA) has developed and funded a number of schemes for the placement and support of health students in rural and Indigenous healthcare settings. You can access information about these schemes on the DoHA website (see Useful Websites as the end of this chapter). Under these schemes DoHA contracts with the university, or a collaboration of universities or an agency to provide: University Departments of Rural Health (UDRH), Rural Clinical Schools (RCS), Medical Rural Bonded Support Scheme (MRBSS), Rural Australian Medical Undergraduate Scholarships (RAMUS), Commonwealth

Undergraduate Remote and Rural Nursing Scholarship Scheme (CURRNSS), John Flynn Scholarship Scheme (JFSS) and the university student Rural Health Clubs (RHCs) programs. There are also a number of state-based initiatives, including the Queensland Health Rural Scholarship Scheme, the NSW Rural Resident Medical Officer Cadetship and the South Australian Allied Health Scholarship Scheme. Each scheme is funded on the basis of key performance areas in terms of the quantity and quality (student satisfaction) of rural or rural Indigenous placements, scholarships or cadetships undertaken.

CHALLENGES AND BENEFITS OF STUDENT PLACEMENTS IN THE INDIGENOUS HEALTHCARE SETTING

As a result of inadequate numbers and maldistribution of the health workforce, and therefore a lack of suitable fieldwork educators, student fieldwork placements in underserved care settings are not always available. This is a challenge to finding you a placement in such a setting.

You may often feel poorly prepared for the greater levels of acuity and urgency of the cases you see, and for the extended practice roles often needed in Indigenous healthcare settings, where in some cases conditions may more closely resemble a Third World healthcare setting than a mainstream Australian healthcare setting. In very remote settings, the paucity of resources can challenge you, including colleagues, family and friends to call on for help, and professional development.

Similarly, health professionals in better-resourced mainstream settings can feel professionally and personally inadequate and poorly prepared to provide for the needs of Indigenous patients who require their care in these settings, which are often very strange and unfamiliar to the patient.

Learning to communicate across cultures continues for a lifetime. While greater understanding can be achieved during your fieldwork placements, culturally based organisations need a high level of cultural sensitivity, which takes time to learn. You will become aware of the challenge of achieving high levels of sensitivity, and may perceive this as a barrier to effective practice in Indigenous health, rather than an opportunity for lifelong learning. You will develop a healthy sense of 'becoming' rather than 'being' culturally competent.

SUMMARY

Student placements in Indigenous health settings accrue benefits to student learning and personal and professional growth as well as to Indigenous health outcomes. Students require preparation for Indigenous health placements in terms of their knowledge, attitudes and cross-cultural skills.

Placements in rural and remote Indigenous healthcare settings have added value as well as added complexity. The knowledge base for what works for student placements in Indigenous settings is based on learning to communicate across cultures and becoming

reflective of the students' worldview and circumstances and sensitive to the worldview and circumstance of Indigenous peoples. Student placements in Indigenous health settings are supported by government policy and strategies.

Discussion questions

1 On deep reflection, what are your assumptions about Australian Aboriginal and Torres Strait Islander peoples?

2 What would be your expectations for a placement in a rural or remote Indigenous healthcare setting?

3 What could you bring to such a placement?

Portfolio development exercise: your local first nation group

Do you know the name of the first nation group where you live? Find out the Indigenous first nation group where you live and gather information about their history, culture, beliefs and health. Is there a role for someone of your profession to work with their community?

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Department of Health and Ageing (DoHA): www.health.gov.au

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PART 2 CHECKLIST

CONTEXTS OF PRACTICE

The following points have been collated from Part 2 of the book. They are a quick reference for you when you undertake placement in different settings. These checklists are organised under the competencies of: professional behaviour, ethical behaviour, communication, knowledge of discipline-specific assessment and treatment, lifelong learning and interprofessional practice (collaboration and working in teams).

Working in diverse settings

Knowledge

- ❑ I can state the difference between public and private hospitals in Australia.
- ❑ I can define what the PBS is.
- ❑ I can state other healthcare settings outside the hospital setting.

Professional and ethical behaviour

- ❑ I can identify five strategies that could potentially be used to aid in my orientation to my placement site.
- ❑ I can define cultural competence in my own words.
- ❑ I can identify four visual aspects of a person's culture and five invisible ones.
- ❑ I can name four things that I need to consider when working with an interpreter.

Interprofessional practice

- ❑ I can name five potential members of an interdisciplinary healthcare team and define their roles.

Working with mothers and babies

Professional behaviour and communication

- ❑ The language used when working with mothers and babies differs from other areas of work. Am I familiar with the terms used? Do I use woman-centred language?
- ❑ Have I prepared or thought through how I will cope with a stillbirth while on placement? Where do I seek assistance to help me cope with this?

Working with children and families

Discipline-specific knowledge

- ❑ I have a grasp of typical development from 0 to 5 years.
- ❑ In my discipline area, I know some paediatric assessments.
- ❑ In my discipline area, I know some intervention strategies.

Professional behaviour

- ❑ I have looked up the service that I will be working in during my fieldwork placement and understand:

- ❑ the age range of children they service and any specific diagnoses
- ❑ the types of families they serve
- ❑ the range of services that are provided.
- ❑ When I observe a session working with a child and family, things to note are:
- ❑ how the health professional engages with the family or caregiver (including listening, communicating, feedback)
- ❑ how the health professional engages with the child (including language used, behaviour management and physical positioning of the child)
- ❑ specific activities and strategies to be used when engaging the child
- ❑ what the child can achieve
- ❑ what tasks or activities were difficult for the child.

Working in acute settings

Professional behaviour

- ❑ Do I know where I am going and how to get to the acute care setting?
- ❑ Do I know where to go (such as ward or department) within the acute care setting?
- ❑ What time do I start? Will I be on placement at night?
- ❑ Do I have my health immunisations up to date?
- ❑ I know I need to take the documentation on my immunisations with me to placement.
- ❑ Do I know the dress code where I will be working?
- ❑ I have my student identification card ready for placement.
- ❑ I realise I can't wear jewellery to my placement except for small ear studs, and fingernails should be short, clean and free from nail polish.
- ❑ I have prepared for the following:
- ❑ the pace of work is going to be fast
- ❑ strict adherence to infection control: Have I washed my hands? Should I wear gloves?
- ❑ acuity of patients: Am I familiar with the patients' conditions I will encounter?
- ❑ the emergency codes.

Communication and interprofessional practice

- ❑ Communication: who is on the interdisciplinary team?

Working with older people

Knowledge

- ❑ I have prepared for my placement by understanding conditions of older persons.
- ❑ I have read up on normal age-related data, so have an idea of what normal ageing entails.
- ❑ I have read about the types of assessment that would be suitable for the setting, including reassessment.
- ❑ I am aware of the types of treatment interventions.
- ❑ I have read about health promotion and prevention activities that would assist the older person.

Professional behaviour

- ❑ I understand that every person is different, and that I need to consider:
- ❑ communication
- ❑ normal ageing
- ❑ the person's condition
- ❑ the setting
- ❑ working in a way that empowers the older person.
- ❑ I understand that I am respectful of the person and call each person by his or her formal name: Mr [name] or Mrs/Ms [name].
- ❑ I am aware that with older persons there may be comorbidities, and that I need to consider these when assessing and planning treatments, including preventative care.

Communication

- ❑ I understand that communication is more than verbal explanation, and that I might need to use demonstration, drawings, gestures and body language to communicate.
- ❑ Some older people may have a hearing aid. I will make sure patients can see my face clearly, so lip reading and facial expression and gesture can be used to augment what is heard.
- ❑ When explaining treatment, I don't use jargon.

Working in mental health

Professional behaviour and ethical behaviour

- ❑ Before I begin my placement, it will help me if I reflect on my understanding of mental health and whether I hold any misbeliefs about people with a mental illness.
- ❑ I have made a list of my fears about this placement.
- ❑ I have found out about the mental health service I will be going to.

Knowledge

- ❑ I know about the range of mental illnesses that people may present with in this setting.

Working in workplace practice

Professional behaviour

- ❑ I understand that I may be required to do a lot of observing on this type of placement because of legal restrictions.
- ❑ I am prepared because I know I need to:
- ❑ wear appropriate clothing and footwear to workplace sites
- ❑ take a pen, paper and enclosed document holder for storing notes and checklists
- ❑ have knowledge of the workplace I am visiting: the type of industry, work undertaken, hazards and history of injuries
- ❑ be aware of site-specific Occupational Health and Safety (OH&S) procedures, e.g. wear required safety gear
- ❑ keep a resource list.

Knowledge

- ❑ I understand that insurance companies are often the clients in this type of practice.

Ethical behaviour

- ❑ I understand I must maintain confidentiality in what I say and write.

Working in private practice

Professional behaviour

- ❑ I am prepared to use my downtime productively; for example, I have prepared readings in areas I need to increase my knowledge.
- ❑ I am prepared to work quickly, as 'time is money' in private practice. Therefore, I have prepared for what I need to get done in the time I have with my client.

Working in rural and remote settings

Professional behaviour

- ❑ I have inquired about the local Indigenous community and whether I will be working with individuals from that community.
- ❑ I have asked about the uniform requirements of the fieldwork placement.
- ❑ I have asked about the placement standards (are there any?).
- ❑ I have asked about my performance assessment while on fieldwork placement.
- ❑ I have checked the following:
- ❑ What are the number of hours I am expected to be engaged in during the fieldwork placement? I will remember that often in remote situations I can have a feeling that I should be engaged every day 24 hours a day. I know that this is unrealistic.
- ❑ What are the start and finish dates for the fieldwork placement? Is travel time included? Who is providing the transport? Is it my responsibility to get to the rural centre, then be transported out to the remote centre? Is there a road trip or a flight on a transport plane? What time do I need to start on day one?
- ❑ Do I need a driver's licence?
- ❑ What is my accommodation like? What is the cost of room, dormitory or tent?
- ❑ Where do I get food and drinks while on fieldwork placement?
- ❑ If I have special dietary needs, are these available where I am going?
- ❑ What am I going to do in the evenings: good book, iPod, computer games, DVDs?
- ❑ What are the options for playing sport?

Interprofessional practice

- ❑ Will I be involved with the Royal Flying Doctors Service?

Working in Indigenous health settings

Professional behaviour

- ❑ I have reflected on my attitudes to Indigenous Australians. Have I tried to be truthful in reflecting whether I am influenced by media reports? Do I know any Indigenous Australians personally?

- ❑ I also checked out:
- ❑ the distances I be travelling
- ❑ who I go to for counselling if I encounter a traumatic event
- ❑ whether my attitudes will change greatly, and if they do, whether they will be in conflict with my family's views on Indigenous Australians.

Knowledge

- ❑ Before starting my Indigenous health setting placement, I need to prepare. This is a helpful list of suggested preparatory work:
- ❑ the history of European settlement and the impact of European settlement on Indigenous people
- ❑ the history of the health service and how it contributes to Indigenous health
- ❑ the predominant health risk factors, and healthcare needs of the health service catchment area
- ❑ how the healthcare service differs from a mainstream service.

Part 3

Transition to Practice

In Part 3, we assume that you are now making the transition from student to health professional. Not only are we assuming that you are a health professional, but we are assuming you will now be taking on the role as a new fieldwork educator. The chapters in this part give you information on transition from student to fieldwork educator and about recruiting students back to your workplace. This may be particularly important if you work in a rural or remote area, or if your workplace is short-staffed.

We wish you all the best in your career as you now venture as a newly graduated health professional.

CHAPTER 24

You Become the Supervisor

Uschi Bay and Michelle Courtney

LEARNING OUTCOMES

After reading this chapter you should be able to:

- put in practice useful strategies from your fieldwork placement experience to assist you with making the transition into working as a qualified health professional
- develop a framework for taking active steps for your continuing professional development
- use the links between your own supervision experiences and your professional development to inform your role as a fieldwork educator.

KEY TERMS

Continuing professional development
Fieldwork education
Fieldwork education supervisor
Fieldwork placement
Fieldwork supervisor
Reflection
Transition

INTRODUCTION

This chapter aims to encourage you to reflect on your experiences of working in your field of practice as a student, and to explore the implications for you in relation to your professional role of fieldwork educator. It is very important for newly qualified health professionals to identify **continuing professional development** opportunities to support current and future work roles. Continuing professional development may be a source of support and satisfaction for you as you move into your professional work. We encourage you to plan actively and pursue various kinds of professional development opportunities. One stimulating form of continuing professional development is becoming a fieldwork educator to students in your field undertaking their first qualification in their chosen profession.

The term '**transition**' often implies that we journey from one destination to another and somehow arrive at an endpoint. However, we feel that we are always in the process of 'becoming' as health professionals, because we are continually learning, relearning and/or unlearning old assumptions to develop new ways of working with people. Hence, the notion of continuing professional development or **lifelong learning** reflects the dynamic engagement with ideas, practices and people that practitioners enjoy throughout their working life.

We aim to support your reflections, conceptualisation and planning for these transitions by outlining various strategies that may assist you with this vital aspect of your ongoing professional practice. This chapter is divided into three sections, each containing information and suggested reflection guides to help you make the progression from student to beginning fieldwork educator.

WORKING IN THE FIELD—AS A STUDENT

Reflection on your fieldwork placement

Moving from *fieldwork placements* as a student into your first qualified professional practice position is an important milestone. This time is recognised as challenging and exciting in the human services and health literature. It is common to feel both eagerness and readiness to go into the workplace to take up your role, but to also be filled with trepidation about how little you feel you actually know. You may be wondering how the skills and knowledge that you have learnt at university and during your fieldwork placement will transfer to new workplace settings and your new job.

One important strategy is to **reflect** systematically (Schön 2003) on your fieldwork experience, your positive and negative feelings, and what moving into the workplace as a qualified health professional means to you.

REFLECTION

YOUR FIELDWORK EXPERIENCE

1 What skills and knowledge do you feel you have gained through your fieldwork placement?
2 What were the joys and sources of satisfaction for you during fieldwork placement?
3 What does this mean to you and your approach to seeking a job in a particular workplace?
4 What were the frustrations and sources of dissatisfaction during your fieldwork placement?
5 What was the value of supervision for you during fieldwork education?
6 What aspects of your fieldwork experience will you seek to take with you into your workplace learning?
7 How has your work-integrated learning influenced your choice of workplaces for practising in your specific field?

8 What areas of professional work in your field would you like to develop further?
9 What workplaces or opportunities are available for expanding and exploring these interests?

From your reflections, what can you learn to inform your career goals? Writing down your responses to these questions may be useful in evaluating and reflecting on your work-integrated learning to inform your choice of job, workplace and continuing professional development priorities.

Reflecting on your responses to these questions can be undertaken in a number of ways; for example, as part of your evaluation (both formally and informally) of the fieldwork placement experience with fellow students or staff at the university, and with your fieldwork educator(s) at the placement organisation. Discussions with fellow students about their **fieldwork education** experiences can help you find out more about a number of practice settings; for example, a large acute city hospital; a community-based placement; experience from a rural and remote site; someone who had no onsite profession-specific supervisor; or in a private practice setting. What were their reflections? What can you learn from this for your own career goals? These reflections can feed into your preparation for your first job as a qualified practitioner.

THINK AND LINK

Section 2, Chapters 14 to 23, discusses a variety of settings and experiences that you may encounter. If, during your discussions with fellow students, there are practice settings where no one in your group has had experience, refer back to these chapters to find the placement setting about which you want more information.

Preparing for your first professional job

As you begin applying for your first professional job and preparing for job interviews, use the **reflection** process to identify the skills and experiences that you wish to use to promote yourself to potential employers.

THINK AND LINK

Chapter 3 is about reflective practice and Chapter 13 also includes a section on reflective practice. These chapters have tools that could aid your reflection process.

Acknowledging that you may not have had work-integrated learning experience in the specific type of job for which you are applying, look to identify transferable skills and/or skills that you have been developing and may be related to the potential job; for example, having experience in administering standardised assessments; attention to following instructions and procedures; and ability to interpret accurately and record the results of the assessment.

You can also promote your ability to work in teams, achieve effective communication with a range of clients and their families and other similar skills that you may have developed during fieldwork placements.

Collating material from your studies and fieldwork placement experiences that enable you to demonstrate your skills to your employer is not only self-affirming, but also conveys your knowledge and ability to learn from experience. You may develop a portfolio as a method of presenting samples of key skills and experiences from your fieldwork placement.

Use the job interview process as a professional development activity in its own right. You can learn more about yourself and your expectations of your professional career by reflecting on the content and outcomes of each job application and interview that you attend. Use this reflection and learning process to update and target your portfolio for each new interview.

CASE STUDY

Jane's fieldwork experiences

Jane has recently completed her **final fieldwork placement** before completing her physiotherapy course. She is concerned that she may not have the specific required and desirable attributes and skills that are listed in some of the interesting job advertisements. After spending time reflecting on her fieldwork placements, Jane identified some skills and experiences that she felt comfortable in promoting to potential employers, even though they may not necessarily be specific to the job:

- 'I have worked with a wide range of clients, and I am comfortable with developing intervention strategies to meet various needs of clients according to age, abilities, lifestyles and cultures.'
- 'I spent some time in a large rehabilitation centre, working with a number of health professionals from a range of disciplines. I feel that I have developed a good understanding of what the various professions can bring to the team and patient care.'
- 'I worked in a rural community setting where there was no physiotherapist. In this situation, I gained experience in problem-solving and communicating with other professionals, clients and the community. I used my initiative to establish a professional support network by contacting a physiotherapist in a nearby town, and the local chapter of the professional association.'

QUESTIONS

1 Reflect on your fieldwork experiences to develop your own examples.

2 Do your examples differ from Jane's, or are they similar?

Moving from being a student to a new health professional can be facilitated by reflecting particularly on your fieldwork placement experiences, gaining perspectives from fellow students and using the job application and interview process as a learning experience. This will enable you to identify a repertoire of relevant experiences, skills and attitudes that you can adapt responsibly to promote yourself to potential employers. As you move on to become a new professional, you can develop and consolidate many of these skills.

WORKING IN THE FIELD—AS A NEWLY QUALIFIED PRACTITIONER

At last—you have started your first job in your chosen profession! In this first year of practice, you may experience both elation and fear, great expectations about the workplace and some coming to terms with the realities of many settings (Morley et al. 2007).

We will now explore some of the key issues and strategies for you in this early phase of your career, with a focus on reflecting on your experiences as a fieldwork placement student.

Orientation strategies

Orientation to your workplace and your role are important early steps for the new health professional, just as they were when you were a student. Induction or orientation programs are important in the transition process, and provide initial pertinent information about the specific job requirements, such as time and place of attendance, use of office space and equipment, resources and client access to resources. Information about communication processes in the organisation is also helpful (Toal-Sullivan 2006). Developing professional support systems, good personal self-care and informal family and friendship networks are also important orientation strategies (Cusick et al. 2004).

Reflect on your fieldwork experiences. What strategies did you use to become familiar with new environments? Did you need a map to help you find your way around your workplace? How did you remember the names of all the staff who were in your immediate and wider working environments? Did you write them down in a notebook? Was carrying a staff contact list with you helpful for remembering names? Did you use a computer-based calendar or reminder system to help you keep appointments, schedule sessions and so forth? If these and other strategies worked for you when you were a student, use them again in your first job.

You may wish to refine or develop these strategies, or you may find new ones, but it is important that you know what has worked for you in the past and is likely to work for you again in the early stages of your new job. This is important not only in the context of starting your new job, but is also important to remember when you begin working with fieldwork placement students; for example, your experience and strategies may be used when developing an induction or orientation program.

Continuing professional development

Your fieldwork placements were a starting point for your continuing professional development. Your university fieldwork liaison person, along with clinicians and others in your fieldwork placement settings, were key factors in shaping your early professional development activities. As you enter the workforce, undertaking continuing professional development should be embedded in your role as a professional. In conjunction with your workplace supervisor, you can identify a range of continuing professional development needs and opportunities for your development as a professional. It is important that you plan and target your continuing professional development activities, so that you can

maintain focus in relation to achieving your career goals. However, there may also be an opportunistic element in your continuing professional development; for example, taking advantage of a presentation by a visiting academic.

Think about how you learnt new skills, and how you responded to the challenges of the workplace during your fieldwork experiences. What is your preferred learning style? Do you learn best by having a skill demonstrated first by a more experienced professional, and then trying it out for yourself? Do you prefer a trial-and-error approach? Do you prefer to try to develop many skills at once, or is your learning style more suited to focusing on gaining confidence in a few skills at a time before moving on to other areas? Are networks in your workplace or wider professional community helpful in giving you the support and feedback that you may require? This may be particularly relevant if you are working as a sole practitioner and/or have a position in a rural or remote location.

You may find that you learn better from some people rather than others. Think back to your fieldwork placements: what strategies did you develop for situations in which the teaching style, for example, of your fieldwork educator, did not facilitate your learning? Did you negotiate to learn from other professionals? Was co-teaching available to you? Did you resolve to learn as much as possible from the individual, and then seek additional learning from another source? These strategies will also apply in your new workplace.

Mentoring is another way in which professionals in all fields are encouraged to identify and develop their ongoing learning in the workplace. The focus with mentoring is usually on career planning and personal development, rather than learning specific practitioner skills or competencies. Some mentoring schemes are formalised, so that an active process is in place for various new workers to be allocated or matched with a mentor. As with best practice in supervision, it is recommended that you establish a contract with your mentor regarding the purpose, process and outcomes of the mentoring relationship.

By reflecting on many of the situations you encountered during your fieldwork placement, you will be able to identify how you can best develop the skills required for your new job. Take responsibility for learning in a style that best suits you. Your understanding of the need for using learning and teaching styles that best suit an individual will be of great value when you work with fieldwork placement students.

As you move on to supervising fieldwork placement students, you will be modelling a professional behaviour: that of being committed to and actively involved in a planned continuing professional development program.

Supervision as a tool for continuing professional development

Your fieldwork experiences contained the key element of supervision. This was a structured process, and you may have felt that the focus was on enabling you to achieve the requirements of the fieldwork placement; that is, passing. As you move into your career as a professional, supervision will take on the focus of being a tool for continuing professional development to develop your skills as a health professional.

In this period of transition, as you begin your new career, you should look for all available opportunities for formal and informal supervision, mentoring and continuing professional development. However, while having a mentor and/or supervisor at this stage is extremely important, you should not assume that you will have access to a supervisor in your workplace (Morley et al. 2007). Do not limit your idea of professional supervision to

line management; that is, your immediate supervisor or boss. There is a difference between line management and professional supervision, which focuses mainly on the development of your professional skills and competencies.

Reflect on the style of supervision that you valued most during your fieldwork experiences. Do you prefer direct feedback, with constructive criticism? Do you have difficulty in receiving negative feedback? What type of feedback and learning from the supervision process enables and inspires you to learn and develop your skills?

THINK AND LINK

There are many types of supervision approaches and these are discussed in Chapter 4.

Be proactive in working with your supervisor to ensure that your learning needs are addressed, by wherever possible using your preferred learning style. This may not always be possible, and will require some flexibility from all involved; however, it is your responsibility to bring these issues to the attention of your workplace supervisor. Reflect on this experience as you begin to work with fieldwork placement students, so that you can best meet their learning and development needs.

Managing expectations

Professional practice is rewarding and challenging partly because it is unpredictable and requires ongoing learning. The pressure you may place on yourself and perceive from others is that you should be able to 'hit the ground running': you expect yourself to know everything and be able to do the work required straightaway. However, it is important to remind yourself and others that it takes time to learn your job, understand the organisation, establish relationships with people and identify all the key stakeholders. Plan actively to learn these various aspects of your work.

CASE STUDY

Sri at work

Sri is a newly qualified social worker employed in an education facility for troubled young people. A young woman disclosed a current situation of sexual abuse to Sri during a one-to-one interview. Sri expected that she, as a qualified social worker, could respond on the spot to this situation, both to assist the troubled student and validate her role in the organisation. Sri negotiated with the young woman for several hours to gain information and consult with relevant agencies before taking action.

QUESTIONS

1 As a newly qualified social worker, how stressed do you think Sri may have been in this interview?

2 Were Sri's self-expectations realistic?

3 If you were Sri, what would you discuss about this situation with your mentor next time you met?

THINK AND LINK

Sri had encountered a vulnerable client. Chapter 12 discusses working ethically with vulnerable clients. Information from this chapter may help you answer the questions to the Sri case study.

If you are overextending yourself, you are likely to miss some of these learning processes. This is why self-care is very important in professional practice. Be mindful too that your co-workers will also be experiencing varying degrees of stress in the work environment. As a team member, understand that your priorities need to be considered along with those of the whole team, so you may need to be patient at times when seeking advice and assistance from others.

It is important for your ongoing personal and professional development to find suitable supervision of your professional practice that allows you to reflect on your experiences, and also to reflect on this process critically as you move into becoming a fieldwork educator.

REFLECTION

WHAT TYPE OF SUPERVISION DO YOU PREFER?

1 What type of supervision did you most value as a student?
2 Is a formalised supervision program available to you in your workplace? Is the supervision practice specific?
3 In your workplace, is your line manager also your supervisor? Is this the right arrangement for you?
4 Are you considering your overall career planning?
5 How can your supervisor and line manager contribute? Would a mentor be helpful?
6 What are your short- and long-term goals for your ongoing professional development?
7 Does your workplace meet your learning needs?
8 What other professional development opportunities are available to you outside your workplace?
9 Are you keeping a reflective diary as a learning tool?

As you move into the next phase of your early career, you should have consolidated some key areas that are essential for a beginning fieldwork educator. You will have a good understanding of the values, expectations and services of your employing organisation. You will demonstrate a range of work skills, including self-management, management in the workplace and profession-specific skills. You will be committed to, and actively engaged in, continuing professional development, supervision and/or mentoring and being a reflective practitioner. You are now prepared for the next phase in the transition process.

WORKING IN THE FIELD—AS A BEGINNING FIELDWORK EDUCATOR

Becoming a first-time fieldwork educator is a significant step, as you experience the transition through various phases of your career. It may seem a daunting role to undertake, but there are benefits, which we will explore briefly in this section, along with some of the key elements of best-practice supervision.

The benefits of becoming a fieldwork educator are many. In the fieldwork educator role you will be required to articulate your professional practice, explain your conceptual maps of the interrelations between theory and practice and explain your organisational setting and policy environment, as well as demonstrating various professional skills and attributes. Your ability to demonstrate competence in these areas will be reassuring as you advance in your career and move on to other roles and positions.

Another benefit of becoming a fieldwork educator is the relationship with university fieldwork education liaison and other academic staff. These connections could lead to other opportunities, such as being engaged as a sessional tutor, marker or deliverer of guest lectures, serving on university committees and providing input to university curriculums and school policy. These are all potential opportunities that would contribute to your career development.

Your professional association or peak body will probably have specific definitions for the different levels of job classification related to expectations about when you should take on supervisory responsibilities. Contact your professional body for guidelines, so that, in conjunction with your employer, you can have a realistic picture of what is expected, and the benefits for you in relation to undertaking student supervision.

The university that has arranged the fieldwork placement is responsible for providing information about the purpose of the placement, including required learning experiences for the student; documentation and assessment requirements; contracts; and all other information that will clearly guide you and the student during the fieldwork experience.

Your role as a fieldwork educator

The fieldwork educator's role comprises three elements: managing, educating and supporting the student in a one-to-one relationship. The management or administrative function of the fieldwork educator's role includes pre-screening interviews, informing agency staff of the student's placement, consulting and negotiating duties, arranging organisational orientation, establishing a learning contract, attending field educators' professional development seminars, liaising and meeting with university staff, and scheduling time for supervision and evaluation of the placement.

When you are planning for the arrival of your first fieldwork student, as a beginning fieldwork educator, it is timely to reflect on all the administrative functions, including induction and orientation to assist the student to learn about your workplace.

CASE STUDY

Leah as a fieldwork educator

Leah is waiting today to meet Chris, her first fieldwork placement student. Leah is feeling excited, challenged and a little apprehensive about how she will perform in this new role as fieldwork educator. In preparation, Leah has completed the following list of actions:

- met with the university fieldwork education liaison person and discussed the work-integrated learning requirements and assessments, and read the relevant documents prepared by the university
- conducted a pre-screening interview with Chris, and gained some idea of the learning objectives that Chris and the university have for the fieldwork placement
- gained organisational support for her new role as fieldwork educator through her own supervisor. Leah's agency provides fieldwork placements for a range of health, social work and human services students
- informed the staff in her immediate team of the arrival of Chris and gained approval from staff for Chris to observe their day-to-day work
- made time available this morning to take Chris on a tour of the agency to introduce him to relevant staff, and has arranged an informal morning tea to welcome Chris
- arranged a desk for Chris to use while attending the workplace, as well as access to the organisation's intranet, and provided a list of times when formal organisational inductions are being conducted for new staff—Leah aims to encourage Chris to attend
- arranged that, on their tour of the organisation, Leah will show Chris the professional library—it should provide some valuable professional reading material
- collected a number of key documents about the organisation for Chris, such as the annual report, the policy and procedures manual and the internal phone directory
- arranged to attend the fieldwork educator workshops offered by her local university for fieldwork educators, to extend her learning about this new role.

QUESTION

What sort of experience do you think Chris will have with Leah as the fieldwork educator?

The teaching role of the fieldwork educator requires attending to the learning style and needs of the student, and being aware of your own learning styles. There is some evidence that a match of learning styles between supervisor and student is advantageous for student learning on placement (Razack 2002). This is an exciting area of learning for new fieldwork educators: Fernandez (2003) argues that the new fieldwork educators should seek awareness of relevant concepts of teaching and learning in preparation for becoming a fieldwork educator. Many universities provide professional development for fieldwork educators as part of their fieldwork placement programs.

Your reflections on your learning and the kind of discussion and supervision that has assisted you to understand learning in the workplace will again assist you in becoming alert to the fieldwork placement learning and supervision needs of your fieldwork placement students.

The key qualities of a good fieldwork educator include being able to identify a range of appropriate theoretical and intervention approaches; the ability to manage anxiety (of both the supervisor and the supervisee); the appropriate use of professional power; a sense of humour; and patience (Hawkins & Shohet 2006).

The third aspect of the fieldwork educator relationship is about supporting the self-awareness of the fieldwork student. Razack (2002) advises that some caution in handling emotional difficulties is required. Only those emotional difficulties that pertain to the student's learning should be included in supervision.

As part of your preparation for this new and exciting role as a **fieldwork education supervisor**, it is important to read some accounts by people like Pereira (2008), who shares the experience of supervising students early in his career. Pereira provides suggestions for making the experience positive for both the student and the new fieldwork educator. Some of the aspects that he emphasises include having clear learning goals and expectations for the fieldwork placement; providing feedback (formal and informal); facilitating self-directed learning opportunities; and undertaking an evaluation before the final evaluation to enable monitoring of progress.

Your reflections on the strategies that facilitated positive experiences for you, both as a fieldwork education student and a newly qualified professional, may assist you with planning your process as a fieldwork education supervisor.

REFLECTION

YOUR NEW ROLE

1. Do you have sufficient information from the relevant university to guide you?
2. Do you have support for your new role from your workplace; for example, time allowed for meeting with students as part of the fieldwork education process?
3. Are you able to access support from others in your service setting; for example, in areas of practice in which you feel less competent?
4. Do you understand the learning style of the fieldwork placement student?
5. How can you learn more about being a fieldwork educator? What are your support networks?

Becoming a fieldwork educator is a significant transition phase in your professional career. You are moving to the next level in your profession, that of contributing to the education of future professionals. Your competence in professional skills, understanding of the key factors in a successful fieldwork education program and involvement in related continuing professional development will enable you to facilitate the fieldwork education of students. Your performance as a fieldwork educator will also be supported by your competence in effective communication and ethical behaviour. Undertaking this role will benefit your future career goals and continually revitalise your practice.

SUMMARY

Work-integrated learning is a key factor in the preparation and development of future health professionals in the human services and health professions. This chapter has explored the phases in career transition from student to entry-level practitioner to beginning fieldwork educator, within the framework of continuing professional development, as being a valued aspect of your vocational life.

Strategies for developing your skills for this role have been presented, including resources for your professional development, your own supervision and mentoring and networking with colleagues. The importance of reflecting on your own experience of fieldwork placements, supervision and practice has been highlighted as a key element in your professional development for the role.

Discussion questions

1 How can your reflection on your experience as a student involved in fieldwork placement inform your plans for your career, including becoming a fieldwork educator?

2 What is the role of reflection on your student fieldwork supervision experience in preparing you to become a fieldwork educator?

3 What skills, knowledge and attitudes do you need to develop to become an effective fieldwork educator?

4 What professional development activities can you undertake to enable you to become a fieldwork educator?

Portfolio developmental exercise: Preparing for the future

Based on your reflections on your fieldwork placement consider the following exercises to consolidate your learning from this chapter:

1 Identify your career goals and define your objectives for further professional development (include an investigation of the possible sources of opportunities for enacting these goals and objectives).

2 Develop an action plan of the necessary steps you need to take to prepare yourself to become a fieldwork supervisor (include identifying your professional association's requirements for becoming a student supervisor).

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CHAPTER 25

Starting Out in Supervision

Liz Beddoe

LEARNING OUTCOMES

After reading this chapter you should be able to:

- reflect on becoming a supervisor: the next step in your journey
- know the purpose of field supervision and the supervisor's key tasks
- discuss fieldwork supervision
- reflect on working with power and difference.

KEY TERMS

Fieldwork education
Personal authority
Placement contract
Professional authority
Reflection
Role authority
Stages model of supervision

INTRODUCTION

As a new graduate you will be busily involved in establishing yourself as a competent health professional, fully engaged in the tasks that process entails: you may be working towards meeting competency goals or logging hours to meet the requirements established by your profession before you can be fully registered. Sooner or later you will be asked to supervise a student for a fieldwork placement in your workplace. Pereira (2008: 247) acknowledges the challenge of taking on student supervision of occupational therapy students in a busy rural setting:

> My own apprehension was further challenged by supervising two students at the same time. How was I going to manage my very busy caseload demands, supervising students and maintaining quality in my assessments and interventions?

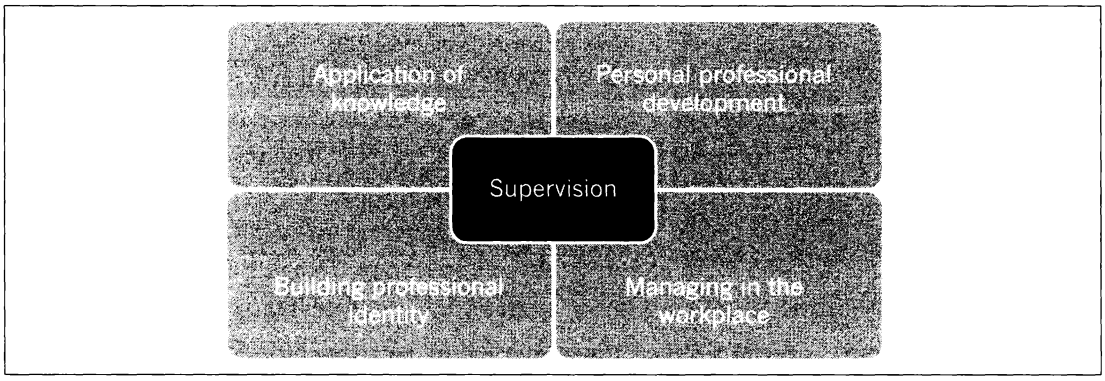
Supervising students is often a precursor to taking on clinical supervision of experienced health professionals. While this chapter focuses mainly on the provision of supervision for fieldwork placement students, it also offers many ideas that will assist you to develop your broad supervision skills. A good starting point is to clarify the purpose of supervision and explore the main tasks and responsibilities of the fieldwork educator.

Professional (or clinical) supervision is a practice that is gaining strength within professions, frequently supported as a dimension of quality assurance to ensure that health professionals are fit and competent to practise (Davys & Beddoe 2010). A focus on continuing competence has led to growing requirements for ongoing professional education and development. Supervision is a significant feature of this environment and Ferguson (2005: 294) provides a broad definition that applies across disciplines:

> Professional supervision is a process between someone called a supervisor and another referred to as the supervisee. It is usually aimed at enhancing the helping effectiveness of the person supervised. It may include acquisition of practical skills, mastery of theoretical or technical knowledge, personal development at the client/therapist interface and professional development.

In student supervision, the primary purpose is to ensure that students have the opportunity to reflect on the direct service they observe, practise specific skills, learn about assessing service user needs, understand the challenges of practice and develop self-management skills in real clinical settings, as shown in Figure 25.1.

Figure 25.1: The focus of supervision

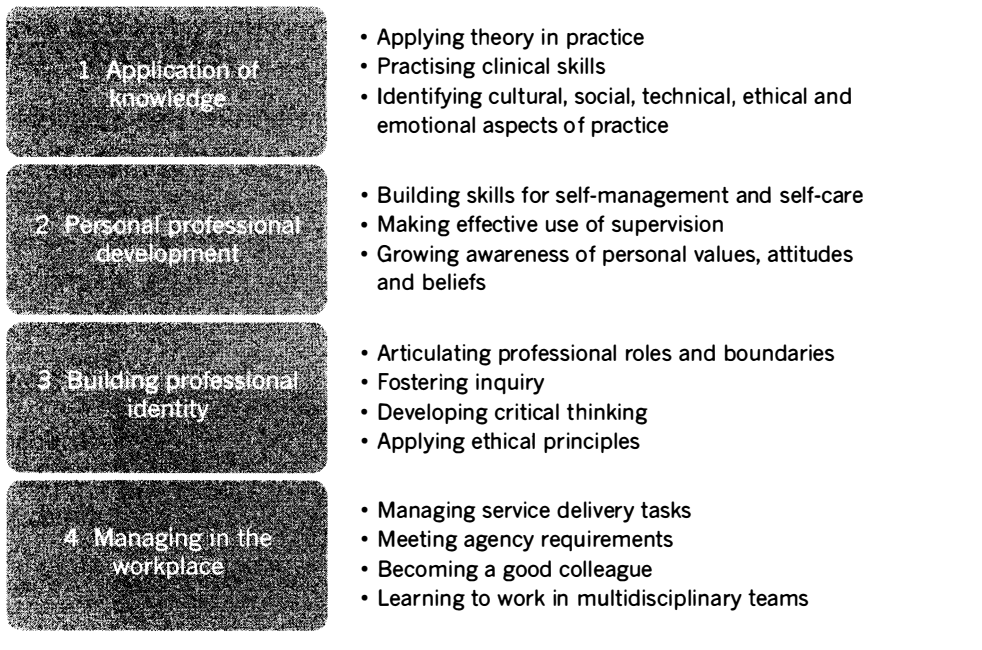


THE FOCUS OF SUPERVISION

Supervision within **fieldwork education** is a structured, interactive and collaborative process that takes place within a purposeful professional relationship. Supervision involves observation, monitoring, coaching and supporting students during their fieldwork placement. Supervision will focus on all four aspects of the student's professional development, as shown in Figure 25.1, and may include examination and exploration of the elements shown in Figure 25.2.

As you can see in Figure 25.2, there are some fairly weighty matters to be addressed in supervision, within the context of an exciting but often stressful fieldwork placement. It is in part because of this complexity that the supervisory relationship between the student and fieldwork educator is of major importance. The fieldwork educator has a dual role within this relationship (Beddoe 2000). She or he must simultaneously motivate the student's professional development while managing their own clinical practice. There are issues of service user safety and organisational administrative imperatives to be accomplished. An effective relationship must be established between the student and the fieldwork educator in order to provide a safe place for reflective learning. Excellent supervision contributes to building professional identity and assists the student to manage the demands of the professional workplace.

Figure 25.2: The focus of the fieldwork placement supervision



The other major contribution of the supervision relationship is to your student's learning, both about the nature of supervision and about managing oneself in professional relationships. These skills help develop a reflective practitioner, who can contribute as a valuable member of a healthcare team. As health professionals, we manage many relationships with supervisors, managers and co-workers, those in other disciplines as well as the service users. In these professional relationships we give and receive feedback, advocate for service user and patient needs, and deal with tensions and conflict. The supervision relationship provides a safe place in which these interpersonal skills can be advanced. As the fieldwork educator, you need to balance support and advocacy for your student with teaching and assessment. You stand in the middle of a 'tangle of relationships and face the demanding task of being both an assessor and an advocate for the student', often in the organisational context (Beddoe 2000: 44). Three phases of the field supervision relationship

and the key tasks in each can be identified, as summarised in Table 25.1. Each phase is discussed in detail below.

Table 25.1: The course of the supervision relationship

Phase	Key tasks
Phase one: Relationship building	• Pre-placement planning • Orientation • Building rapport • Clarifying mutual expectations of supervision • Exploration of practice styles and theoretical orientations
Phase two: Consolidation of learning and development	• Managing anxiety and emotions • Managing the dependence-autonomy continuum • Exploring the professional environment • Strengthening the feedback process • Reviewing learning goals and achievement
Phase Three: Review and ending	• Evaluating the relationship • Managing impacts of assessment and endings • Reviewing placement learning and achievement of goals • Saying farewell

Phase 1: Building the supervision relationship

One of the immediate tasks facing the new fieldwork educator is the application of discipline-specific skills in a new dimension of practice. There are five main elements in this process of translation:

› the ability to work with the service user or patient at arm's length instead of hands on
› the capacity to work with the emotional reactions of the student in the midst of their learning
› the recognition of the centrality of the teaching dimension of supervision in supporting students to achieve their learning goals
› thoughtful planning of practical clinical activities to instil confidence
› developing an understanding of the separation of the *process* of supervision from the *role* of fieldwork educator.

The process of becoming a fieldwork educator involves developing the ability to stand back from using one's own knowledge and skills actively with service users or patients, and instead taking a role one step back in order to facilitate development in the student. There are benefits for both fieldwork educator and student in this process.

Urdang (1999) studied the experience of a group of social work practitioners as they began to supervise students on placement. A key finding was that fieldwork educators' self-esteem increased, both through mastery of a new skill and the validation, through teaching and supervising the student, of their own knowledge base and practice. Most fieldwork educators indicated that work as a fieldwork educator increased both their self-awareness and capacity to analyse their work, much of which had become automatic (Urdang 1999).

Nothing influences the effectiveness of supervision more than the quality of the supervision relationship itself (Bond & Holland 2010). When you begin to prepare for your fieldwork educator role, it is very useful to explore your own professional journey, the strengths and challenges you face in your own work and consider what it is you have to offer a student. New fieldwork educators often feel ambivalent, as they 'simultaneously relish the opportunity to influence a new health professional, whilst fearing the student's critical gaze' (Beddoe 2000: 45). You will also be evaluated during field education: by the student, by the educational institution and by your senior colleagues in your workplace. You may suddenly feel less confident about your own practice, and be worried that you are not good enough for the task of supervision. In your own supervision you can reflect on your personal experience as a student and the aspects of good supervision you want to emulate, and the things you might want to improve upon or even avoid. You may wish to write about this experience in a reflective way.

THINK AND LINK

Reflecting on your experience of fieldwork placement when you were a student is a good starting point to understanding yourself as a fieldwork educator. Refer to Chapters 3 and 5, which provide some practical tools to guide you through reflection. Chapter 24 discusses and provides reflections about the transition from student to fieldwork educator.

A student in one of my courses once asked, 'When does it stop? Should my supervisor get supervision too? And her supervisor …?' This may seem absurd as long as we are influenced by an image of a hierarchy. Instead, it may be more attractive to see the process as a chain of supervision relationships by which health professionals are linked to each other to nurture safe and effective practice in health and social care.

Seek ongoing professional education for your role as a fieldwork educator, including attending seminars, studying formal and higher qualifications in supervision or fieldwork education or refresher courses. Shared activities with other health professionals who also work with students can provide additional learning opportunities for fieldwork educator and student alike. Learning to work alongside other professionals in healthcare settings is an important aspect of fieldwork education. As a fieldwork educator, you can play a significant part in ensuring your student has opportunities to work alongside other disciplines and learn how each has a role, perspective and, often, professional culture and expectations about how to relate to service users and others. This provides rich opportunities for learning, both from other bodies of knowledge and from the experience of teamwork (Smith & Anderson 2008).

THINK AND LINK

Continuing professional education is important to all health professionals. Chapter 24 discusses continuing professional education from your learning needs. Learning to *work alongside other professionals is also important for service delivery. Chapter 8* considers working in teams and interprofessional learning.

CASE STUDY

Learning to work together

Ashwaq and Miranda are your two occupational therapy students. Their placement coincides with the fieldwork placement of Robert and Philippa, who are social work students. The setting is a busy community-based child development team attached to a children's hospital. You and Christina, the social work educator, are both relatively new to your fieldwork education role, and feel there will be benefits in sharing ideas and even planning to bring the students together. You get together before the students arrive and plan some joint activities.

At the halfway stage, you and Christina decide to compare notes about how your fieldwork education roles are going. You find that you have one student who is hard to engage in one-to-one supervision. You use your peer supervision relationship to rehearse some ideas, and agree to try a joint supervision session to see if this is helpful. In this session some discussion of patients known to all the students results in an interesting and lively debate about roles and approaches. At the end of the session the students agree to meet without you to discuss their projects. At the next combined session the students propose joint home visits to several families. Together they have come up with some exciting and creative programs for two children with complex needs.

QUESTIONS

1 Would you consider this to be a successful outcome of supervision?

2 What outcomes are positive from your point of view? Are there any negative outcomes?

It is important to remember that students are not all the same; many will be young and still developing their personal skills and belief systems; some will be mature students and some may be training in a new profession and having to adjust to being a novice again. Students may also feel anxious that their fieldwork education experience will contain challenges, especially from service users and other professionals. Students are often very anxious about exposing their lack of experience and skill as they test out their skills in new situations, and even very confident students may approach the practice environment feeling uncertain about their abilities. It can be helpful for you as a new fieldwork educator to share some of your thoughts and feelings, and perhaps to share some of your own journey from student to professional to fieldwork educator. Being open to an exploration of mutual hopes and concerns will help build a constructive and trusting relationship.

Clarifying expectations

The **placement contract** in fieldwork education addresses the specific expectations between the student, the supervisor and the education institution. This agreement will have addressed practical matters, the timeframe of the placement, agency conduct rules, arrangements for supervision and backup during the absence of the fieldwork educator. An additional discussion of the boundaries of the supervision relationship itself, especially the role of support, will be needed (Davys & Beddoe 2010). Remind your student that old and new personal issues may be triggered by stressful situations encountered in practice, and that

you can support her or him when seeking appropriate professional help elsewhere. It may be useful to discuss specific examples of such possibilities and how they would be dealt with in supervision.

In checking out your students' understanding of the role and purpose of supervision, you could direct your student to some reading about how to make the most of supervision. Davys (2007) suggests that the critical success factors include: understanding the purpose of supervision; knowing what you want from your fieldwork educator; taking an active role in negotiating a contract; and preparation, active participation and willingness to be open and reflective in each supervision session (Davys 2007: 28–39).

Phase 2: Consolidation of learning and development

Once the supervision relationship is established and you have started to work together, there is a period of consolidation when you build on the good foundations laid down earlier. One of the many differences between student supervision and supervision of qualified practitioners is that all the work of relationship building and beginning the practice learning process needs to happen very quickly because of the short timeframe of the fieldwork placement. Several key elements contribute to the consolidation of a positive relationship to support student learning (Davys & Beddoe 2010; see Figure 25.3).

Figure 25.3: Student and practitioner supervision: Key differences

Supervising practitioners	Key elements	Supervising students
Long-term	Duration	Short-term
Agency needs	Workload	Limited
Develop and maintain competence	Primary goal	Learning
As required/audit	Monitoring	Close observation
Annual/linked to work performance goals	Assessment	Detailed/frequent/ linked to educational goals
Moderate support, administrative needs and professional development	Administrative, educative focus and support needs	Considerable support/focus on development and integration
Worker led	Agenda setting	Equal input
Worker, agency, profession, clients	Accountability	Student, school, agency, profession, clients

Source: Davys & Beddoe 2010

The themes of the middle phase of supervision include consolidation of learning; experiencing feedback; and managing self in the workplace. During this phase, some students may experience conflict between their need for their fieldwork educator to be in charge and their emerging sense of professional competence. Therefore some will seek greater autonomy. For others, lack of confidence may mean they require considerable support to undertake even relatively simple tasks. Good preparation for undertaking discipline-specific activities, with clear parameters, opportunities for *reflection* and regular review are all essential components in building student confidence. The provision of planned opportunities for observation of students' clinical work, followed by structured feedback and self-assessment can contribute to a growing sense of professional accomplishment (Beddoe et al. 2011). Ideally, during this phase students can experience some independence while appreciating constructive input and oversight of their work.

A **stages model of supervision** utilises a developmental approach to these issues. Table 25.2 outlines the stages of supervision in relation to a dependency–autonomy continuum as students learn to become more autonomous. It is, however, important to remember that a limitation of developmental models is that they can impose generalised expectations. Each student will be unique. A mature student such as Nita (see the case study below) will build her own pathway. Initially anxious in a new role, she finds her voice, and draws on old skills to show initiative, even if a little prematurely from her fieldwork educator's point of view.

Table 25.2: Supervisee levels of independence

Levels	Dependency to autonomy	Features of level
Level One	Dependency	Anxiety—the supervisee needs structure, rehearsal of tasks, encouragement and supportive feedback.
Level Two	Fluctuation between dependency and greater independence	Initial anxiety reduced. May undertake some tasks with confidence but lacks flexibility. Improved focus and may start to question practices and the supervisor's authority.
Level Three	Proficiency and confident independence	Greater confidence and proficiency in most professional tasks. Some flexibility and creativity in unexpected situations. More self-directed in supervision and is reflective without prompting.
Level Four	Professional autonomy	Greater insight. Deepening awareness of 'self-in-action' in practice. Uses supervision to explore ideas to extend repertoire of treatment ideas and interventions.

CASE STUDY

Nita

Nita is a mature physiotherapy student being supervised by Mary, who has been registered for five years. Nita has changed career at the age of 40, having practised as a registered nurse. Mary works in a very busy outpatient service in a large teaching hospital. One of the features of this setting is that, as well as seeing 'booked' patients, it also admits urgent assessments at very short notice when there is pressure to achieve early discharge. Initially Nita, who lacks confidence, is a very anxious student, and in the first two weeks of

her fieldwork placement checks everything three times with Mary. Every time Mary turns around Nita is there with a new question, some days with so many competing demands that Mary feels overwhelmed and thinks, 'Why did I agree to take a mature student?'

She perseveres, and through a process of trial and error finds that Nita's confidence grows through having a step-by-step written plan for even simple activities. In the last week of the fieldwork placement, Mary is very surprised to return from her lunch break to find Nita has independently started an assessment with a patient referred from a ward. She is motivated by a wish to be helpful and prove herself, but without waiting for Mary's approval, she has changed the appointment board in the clinic and liaised with the nurse managers about the rescheduling of appointments. Mary acknowledges Nita's enthusiasm and initiative, and gently reminds Nita of her role and the limits of her autonomy. Nita laughs and says, 'Oops! My inner staff-nurse just popped up!'

QUESTION

The line between autonomy and dependency can clash with role boundaries about what is the student role. In Nita's case, was it autonomy, dependency or role boundaries that were the issue when she organised a patient assessment independently?

Managing authority and power

A key to the effective and non-oppressive use of power and authority in supervision is the clear understanding of the differences between the *role* and the *process* of supervision. The supervisory role is imbued with authority and power. Both fieldwork educators and students bring to this new relationship their ideas, beliefs and the 'baggage' of previous experiences of authority. Both may fear being 'found out' as having less knowledge than they should. Both parties need to be able to create a place where it is all right not to know. The situation in the case study could have ended badly, if (a) Nita had been offended and had retreated to anxiety, or (b) Mary had not addressed the issues but had still felt uncomfortable.

Hughes and Pengelly (1997: 168–9) distinguish between three sources of authority in supervision: **role authority**, conferred by the organisation and the university; **professional authority**, earned through credible practice of knowledge and skill; and **personal authority**. Personal authority stems from the individual's demeanour and ability within professional relationships to exercise the other two forms. Too much reliance on any of these sources of authority leads to conflict in supervision. Too little exercise of legitimate authority can lead to collusion and the collapse of safe practice. Students need to know that their fieldwork educator has the confidence to exercise authority if needed in order to challenge unsafe practice. Coming to terms with the authority that comes with your new role can be challenging. In the new role there is a partial shift away from direct discipline-specific work towards changed relationships that need to be forged with colleagues, managers, educators and students. New fieldwork educators often feel that they are exposed to a critical gaze from all sides.

THINK AND LINK

Chapter 4 discusses models of supervision. It may be relevant to you to review this chapter now.

Emotional awareness

Supervision is part of the constellation of resources that health professionals can call upon to manage the anxiety and uncertainty generated by clinical practice, especially because of the current emphasis on risk management. In many professions there are somewhat contradictory themes: on the one hand, health professionals may feel pressure to undertake evidence-based practice; on the other, they are urged to trust their feelings and listen to hunches. Supervision provides a space in which these competing concerns can be attended to, thus allowing room for the safe expression and exploration of feelings; they may contribute to growth and provide a rich source of information about service users' strengths and vulnerabilities (Hughes & Pengelly 1997: 79–91).

Supervision that recognises health professionals' emotional responses as valid and significant may provide a key to safe practice.

Many barriers prevent the exploration of feelings in supervision. Fieldwork educators may be too busy and task focused to ask feelings-focused questions or encourage deeper reflection. Some supervisors may find feelings messy and unwelcome, and believe they should be minimised in the discussion of cases, especially if they wish to be perceived as scientific and objective. Hughes and Pengelly (1997: 176) note that containment of emotion in supervision is often used as if it were a means of control: 'keeping the lid on'. They prefer to think of it as 'the process in which authority becomes translated into effective interaction'. Most students want more from supervision than empathetic hand-patting. In reflective supervision, taking the lid off is essential, not to expose or treat the student, but in order to explore the impact and the implications of strong feelings on practice. In dealing with the emotional content of supervision, feelings may be subject to accommodation or, in a contrasting approach, the exploration of feelings may lead to more reflective practice, as shown in Table 25.3. In an exploratory process, feelings can be both accepted and valued as a rich source of information and ideas. It is possible to experiment widely with a range of strategies that can be constructed, challenged and rehearsed within a safe space. If feelings are merely accommodated, then the fieldwork educator may rely on prescriptive approaches to avoid too many difficult questions.

Where does the professional boundary finish and stray over into the personal? A general rule of thumb recommended by most is that supervision should focus on personal matters only when they have a direct impact on the work. Supervision can bring into focus all the key elements of interaction with clients: our feelings and use of self in our work, our understanding of and reactions to the experiences of others, our skills, our knowledge base and our ability to manage all of these in a helping relationship. A brief case scenario may illustrate this point.

Table 25.3: Coping with uncertainty

Accommodation supervision style	Exploration supervision style
• Seeking for 'known' things	• Accepting there is no absolute knowing
• Rules for action	• Seeking more questions
• Prescriptive interventions	• Exploration of uncertainty
• Task-orientated practice	• Reflective practice and willingness to experiment
• Blueprints to determine action	
• Obsession with predetermined outcomes	• No fixed expectations of outcome
• Low tolerance of feelings	• Open exploration of feelings
• Feelings to be tidied away and minimised	• Feelings as evidence for practice

CASE STUDY

Josie

Josie is a 28-year-old social work student who has just started a 16-week placement in a busy surgical service. Today she comes to supervision with a very difficult issue to talk about. At your suggestion, Soli, a senior practitioner, has invited her to co-work in a new case just referred to the service. The patient is Lucy, a 49-year-old woman with four children aged between five and fifteen, who has just been given a diagnosis of breast cancer with an uncertain prognosis. Josie's mother had surgery for breast cancer just one year ago. She is currently well, but the family is still fearful about the future. Josie is dreading going to meet Lucy. She really wants the opportunity to co-work with Soli, but her eyes filled with tears when she read the referral. She wonders whether she'll cope. She's frightened that when she sees Lucy she'll be reminded of her mother, and that her grief will come to the surface.

Josie is faced with painful issues. First, she needs to be supported for being open about her distress in her supervision session. Being able to be honest and vulnerable is important for learning. In this situation it's really important that Josie is able to talk about her feelings and shed some tears if necessary. It is equally important that her fieldwork educator has the ability to listen and hold her distress.

The second part of this supervision encounter will be working out with Josie whether she can work with Lucy and her family in a support role alongside Soli, or whether it is too soon for her to deal with a situation so close to her own heart. Her fieldwork educator has the responsibility to help her talk through this situation, and together to come up with an approach that affirms Josie's emerging self-management skills.

KEY SUPERVISION QUESTIONS FOR YOU AS JOSIE'S FIELDWORK EDUCATOR

1 What do you need to focus on in the exploration of this issue in supervision?
2 What strengths does Josie's personal experience give her in working with Lucy? What can make her vulnerable?
3 What are similar aspects in Josie's story, and what are different?
4 How might Lucy's practical and emotional support needs be different from those of Josie, because of her culture, her socio-economic situation and her family structure?
5 What steps do you take next? What support do you need to give Josie? What resources do you need?

Ethical practice in complex contexts

Supervision is often seen as the site for ethical teaching. This would be fine if ethics were a simple matter. However, as you may already have learnt in your professional journey, they are more likely to be messy and confusing. Professionals are subject to the scrutiny of regulators, an often critical media and the public.

As a consequence, students and interns and their supervisors may feel a deep sense of insecurity about the lack of clear unequivocal ethical rules. The diversity of postmodern perspectives may be confusing, and values that seemed unquestionable may be disputed,

especially when professionals work with service users from diverse worldviews. Fieldwork educators can provide guidance by fostering the following attributes: valuing diversity; providing empathetic responsiveness to the lived realities of others; recognising that each professional encounter is unique; and teaching skills for negotiating complex and contested decisions. Hugman (2005) reminds us that it is critical that senior practitioners in the helping professions model thoughtful engagement with people and ethical reflexivity. Students need to be 'able to accept and deal with uncertainty and ambiguity, and the absence of cookbook solutions' and to 'learn that when moral conflicts or ethical dilemmas arise, they can only be resolved through dialogue and a process of moral reasoning' (Gray & Gibbons 2007: 224).

THINK AND LINK

Chapter 12 discusses working ethically in context. This chapter will add more information to ethical questions which may arise in supervision, and Chapter 13 discusses working in palliative care.

Phase 3: Review and ending

The final phase of the student supervision relationship involves tasks of closure and evaluation. The process of assessment may dominate all other considerations at this phase. During this phase, you as the fieldwork educator need to assess honestly and report on the student's achievement according to the formal requirements of the fieldwork placement, while continuing to facilitate learning in a supportive environment. Student anxiety about the final assessment can be reduced by continuous feedback and review throughout the placement. The fieldwork educator can help the student to see the final assessment as yet another milestone in their journey to being a fully qualified and competent practitioner. While the assessment may be, in the placement context, summative, the student is engaged in continuous learning, and will ultimately take this experience into a professional career in which he or she will experience many appraisals.

THINK AND LINK

Assessment is a key aspect of fieldwork placements from the student's perspective. Chapter 6 discusses assessment in fieldwork settings, and Chapter 9 discusses what happens when students fail.

Two further tasks complete the fieldwork placement. The first undertaking is to review how well the supervision relationship has assisted the student's learning. This should include feedback from both participants about the achievement of the learning outcomes and the experience of supervision itself. The second task is to embark on farewells, with careful attention to both formal and informal processes. The fieldwork placement, often a major experience for students, will shape some of their perceptions of the profession and how it is conducted.

SUMMARY

Becoming a fieldwork educator is more than a rite of passage for a health professional. It requires the management of some key tasks in revisioning practice with a different focus. It requires individual consideration of professional identity, culture and the processing of your own relevant personal experience; for example, the experience of being supervised, the experience of power and authority and the development of complex teaching and learning skills.

Discussion questions

1 Have you thought of activities to support interprofessional learning?

2 Do you have a plan for your own support?

3 Are there potential benefits from working with fieldwork educators from other disciplines to the benefit of your students and your own practice?

Portfolio development exercise: Reflection for the fieldwork educator

> Far from beginning with a clean slate, the new supervisor will be a blend of all that has gone before in their personal and professional lives (Brown & Bourne 1996: 19).

Write a brief personal professional biography. Describe your motivation to enter your profession; your key personal values; the theories and interventions that have shaped your practice; the model(s) of practice you most favour; and your personal perspective on the nature and direction of your profession.

Add to this a brief description of your experiences in your own fieldwork placements, noting the successes and challenges you faced, and how you managed your anxieties.

Then either on your own, or with your supervisor, address the following questions:

1 What worked best in your fieldwork placement supervision when you were a student?

2 If there were difficulties for you, what were they, and how might you avoid them in providing supervision for a student?

3 What are your worries or fears about the student supervision?

4 What are your hopes for this new aspect of your professional career?

5 How will you go about building an effective, enjoyable relationship in supervision?

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CHAPTER 26

Health Workforce Recruitment and the Impact of Fieldwork Placements

Adrian Schoo, Karen Stagnitti and Brenton Kortman

LEARNING OUTCOMES

After reading this chapter you should be able to:

- discuss the links between fieldwork placement and workforce recruitment
- describe the features of fieldwork placements that are likely to encourage students to apply for subsequent positions
- prepare fieldwork placements in view of future recruitment of staff.

KEY TERMS

Fieldwork placements	Orientation	Supervision
Graduate	Rural health practice	Workforce recruitment

INTRODUCTION

This chapter outlines the links between **fieldwork placements** that you have undertaken and the jobs that you apply for. '**Workforce recruitment**' refers to the process of employing someone to fill a vacant position. It incorporates preparing a job description, obtaining approval to fill the position, advertising and recruitment strategy, selection process and filling the position. Workforce recruitment is important in both metropolitan and rural settings because of the shortage of health practitioners to fill available positions. The objectives of the chapter are to establish the influence of the fieldwork placement in **graduates**' choice of workplace setting; the issues around placement and workforce recruitment; and what workplaces can do to encourage students to return as graduates to work in their institutions or centres.

FIELDWORK AND STUDENTS' CHOICE OF WORKPLACE SETTING

Fieldwork placement and the timing of the placement have been associated with students' choice of workplace setting after graduation and are as important as other recruitment strategies such as advertising or word of mouth (Mulholland & Derdall 2005). A study by Doherty and colleagues (2009) found that occupational therapy graduates' decisions to apply for particular positions were strongly related to their fieldwork placement experiences. For example, they found that a student's experience in a non-traditional placement was significant in a student's choice of a community-based career (Doherty et al. 2009). The connection between where students undertake fieldwork placement and their strong preference to practise in a particular area is not a new concept. Crowe and Mackenzie (2002) also reported fieldwork placements to be the most important factor influencing a student's decisions to pursue an area of practice upon graduation. Of particular note, fieldwork placements completed in the latter part of a student's degree are most influential in persuading the student to choose a certain area of practice. Fieldwork placements undertaken near the end of a degree, together with a positive experience at the fieldwork placement, effective partnerships between the placement and university and a student's sense of effectiveness in the area are the most influential factors determining speciality choice of graduates (Mulholland & Derdall 2005; Frank 2008). The evidence that fieldwork placements have the potential to strongly influence practice preference of new graduates suggests that agencies should carefully consider how they prepare and coordinate fieldwork placements to maximise the likelihood of students applying for vacancies as they arise. The conditions for a positive learning experience in fieldwork placements have been covered elsewhere in this book.

THINK AND LINK

Preparing for your fieldwork placement was covered in Chapter 1. Students who prepare well for a placement begin in a less stressed state. Chapter 5 presents valuable activities for students and supervisors to enable them to get the best out of their placement.

REFLECTION

THE LAST PLACEMENT

Consider your last fieldwork placement undertaken as a student.

1 Was the placement a positive experience?
2 Did you feel effective in the work you undertook at the fieldwork placement?
3 Was the fieldwork placement influential in where you work now? Why or why not?

PLACEMENTS AND WORKFORCE RECRUITMENT: THE EXAMPLE OF RURAL AND REMOTE SETTINGS

One of the areas where the link between fieldwork experiences and recruitment has been studied is in rural and remote practice and this provides common concepts that can be used in any setting. For students undertaking a rural fieldwork placement, the conditions that contribute to an effective placement also have some distinct differences from placements carried out within the student's familiar geographical region. This highlights the importance of considering the distinct features of the practice environment in developing effective placements.

THINK AND LINK

Rural and remote settings can be challenging for some students. Chapter 22 discusses what to prepare for in rural and remote fieldwork settings. Refer to Chapter 22 for more information about these settings.

Students who experienced a rural placement, and who were surveyed after their fieldwork placement (Burch & Newman 2007), listed the top five most important points that had an impact on their overall experience as:

- the skill of the fieldwork educator in giving a positive learning experience
- the experience of combining a variety of work, including patient access, assessment and treatment, with a variety of clinical conditions
- fieldwork educators and mentors who were professional, gave peer support and were friendly
- the presence of infrastructure support, such as affordable and available accommodation
- the opportunity to see a variety of parts of Australia while learning about rural health issues within the local context.

In Burch and Newman's (2007) survey, positive aspects of the rural fieldwork placement were counterbalanced by concerns raised by the students. Students' concerns included:

- the quality and costs of accommodation, because rural fieldwork placements require a student to relocate for a short period of time. The experience of accommodation can be positive or negative. For some students, paying for accommodation during the fieldwork placement was an onerous burden
- the expenses incurred during fieldwork placement, together with loss of income and being unable to work
- isolation and separation from family and friends and usual sources of social support
- commitments of family and partner, partner's needs and housing commitments
- isolation and distance from the university or teaching site, with the student sometimes missing lectures (the sense of isolation was exacerbated if the student experienced a poor learning experience)
- students requiring clarification of what they should expect, with more information on the caseload they would be working with (Burch & Newman 2007).

Many of these positive experiences and concerns would also potentially apply to any student locating to a different geographical area for placement than where their university is based, such as students on placement from interstate locations even in urban areas.

In an endeavour to establish whether rural placements actually translate into graduates seeking jobs in rural areas, a study of 429 allied health and nursing students showed that, after controlling for rural background, the value and duration of rural fieldwork placement were significantly associated with rural employment after graduation (Playford et al. 2006). Although having a rural background influences graduates' choices of commencing careers in a rural area, rural fieldwork placement is an important strategy that can be used to influence students' intention to take up a rural position. Several universities have started to recruit from and train in rural areas, and so far the effects are very positive. For example, more than 70 per cent of the pharmacists trained at Charles Sturt University remain practising in rural townships (Barton 2006).

Survey results for nursing students' pre- and post-rural fieldwork placement found a 12 per cent increase in the number of graduates intending to seek rural employment (Courtney et al. 2002). Interestingly, more than 30 per cent of the nursing students who opted for rural placement had no previous experience of a rural lifestyle, and more than 50 per cent of this subgroup indicated their intention to seek rural employment after their rural fieldwork placement (Courtney et al. 2002). In medicine, positive rural fieldwork placement and education have been shown to increase interest in **rural health practice** (Eley & Baker 2005). For a rural fieldwork placement to be positive, it must be matched with a positive fieldwork environment in order to increase interest in rural practice (Eley & Baker 2005). Hence, equipping health professionals with adequate supervisory skills is an essential strategy to increase the chance that students have a positive fieldwork experience.

THINK AND LINK

For a new fieldwork educator, supervising his or her first student can be daunting. Chapters 24 and 25 discuss different aspects of the transition from student to fieldwork supervisor, with Chapter 25 discussing in detail the three phases of supervision.

WHAT WORKPLACES CAN DO TO ENCOURAGE STUDENTS TO RETURN AFTER FIELDWORK PLACEMENTS

Fieldwork supervisors indicate that one of the most commonly reported benefits of having students is the potential recruitment of future employees (Thomas et al. 2007). Students who become employees already have been orientated to the agency and are more likely to be job ready for that particular environment. Consequently, managers and supervisors should consider each placement, particularly final year placements, as opportunities for recruitment and hence prepare the placement accordingly. A good work-integrated learning experience is underpinned by the opportunities provided by the fieldwork placement, as well as the skills of individual fieldwork educators and relationships between the university and the placement (Burch & Newman 2007; Frank 2008). The role of the fieldwork educator,

orientation to the setting and specific placement characteristics, such as caseload, are aspects of a placement that may encourage students to return. Keller and Wilson (2011) identified that students seek employment in their placement setting if the teams operate well, their profession is respected and the *supervision* they received was effective. Conversely poor supervision or teamwork are likely to be factors that reduce the likelihood of a student applying for a position. Consider John's story below.

CASE STUDY

John leaves home for the country

John had never left home before. He had never been out of the city for any long period of time, so commencing his **final fieldwork placement** in a small rural town 100 kilometres from his home filled him with trepidation. He had many misgivings. He would have to take leave from his permanent part-time job, he wouldn't see his friends each week and he had no family support where he was going.

When John arrived on his first day, his fieldwork educator welcomed him. He was introduced to all the staff, he was orientated to the procedures, policies and routines of the service, and he was also invited to join the local basketball team while he was on placement. The team was called the Good for You. John's fieldwork educator structured supervision sessions so that he could build on his knowledge and extend his clinical reasoning skills.

After several weeks, John finished his fieldwork placement and it was time to return home. To his surprise, he was sad to leave. During his placement he had made some real bonds with the staff, he really enjoyed playing on the basketball team, he was never lonely and he had had exposure to a wide variety of clients. When he finished his degree, he rang the service in the small rural town to see if there were any positions available.

QUESTIONS

1 List the factors that may have influenced John to apply for a job in this small rural town.

2 What could have happened during John's rural placement that might have turned him against the experience? If John had had a negative experience, do you think he would have considered going back to the small town?

REFLECTION

WHERE WOULD YOU WORK?

1 As a health professional, how could your actions influence a student to seek employment with you?

2 As a student, what would convince you to apply for a position where you just finished fieldwork placement?

Apply these reflections to your fieldwork program and list aspects you may be able to change or add to maximise recruitment.

The fieldwork educator

Optimising the skill of the fieldwork educator is one significant way a workplace can influence a student to return as a graduate. Training health professionals to be a fieldwork educator is of double benefit: it assists both the professionals themselves (particularly new recruits who are inexperienced in student supervision) and the students they supervise. Rural health professionals who are supervising students frequently:

- value the contribution they make to students' knowledge and skills
- take the opportunity to promote rural practice as a career option to their students
- enjoy the teaching role as a fieldwork educator
- are stimulated by being a supervisor and keeping up with professional development
- tend to increase their time reviewing their discipline-specific knowledge (Shannon et al. 2006; Frank 2008).

Supervision training needs are generic across the health professions, and can be taught in a multiprofessional training program (Hook & Lawson-Porter 2003). Supervisors who encourage graduates to become competent in performing routine tasks before moving them on to complex tasks requiring a high level of clinical reasoning are valued by new graduates (McInstry 2005).

Fieldwork educators should be provided with basic training, then supported and given access to specific workshops or seminars in their region. Onsite and web-based training programs exist in Australia and are often provided by university health professional programs. In Victoria, a government-funded support network for clinical supervisors with online training, which is relatively cheap, can be accessed at any time by the clinician. The Victorian support network for clinical supervisors organises in each region regular workshop meetings that are accessible by videoconference. It records presentations and makes it available for viewing online and facilitates discussion online.

Experienced supervisors may appreciate being able to attend and contribute to advanced supervisory education sessions or assist in developing fieldwork or curriculum processes. The ability of the supervisor to be a positive and effective teacher, mentor and role model is potentially the most influential factor on recruitment.

THINK AND LINK

Chapter 24 discusses continuing professional education as important for the health professional, and that supervision of a student can also be seen as professional continuing development. Chapter 10 expands on the online technology that is available for students and fieldwork educators.

Orientation and support networks

For a previous fieldwork student returning to a workplace as a graduate, supervision and support from experienced health professionals and orientation to the workplace can help them make the transition to practice (Stagnitti et al. 2005). Frank (2008) gave an example

of a university where academic nursing staff were partnered with a health service and assisted in orientation of students and new staff, which resulted in students gaining employment from their fieldwork placement as well as remaining employed by the service one year later.

Orientation is important both for fieldwork experience and for beginning a new position as a new graduate. When health professional students are orientated to the new fieldwork placement, they experience low levels of stress. New graduates have been found to adapt to the workplace more quickly if well orientated to the new workplace (Frank 2008). During John's fieldwork placement (see the case study) he was both well orientated and integrated socially by being invited to join the basketball team. Fieldwork educators who have good support networks in place are well suited to student recruitment from their regions.

Variety of caseloads and responsibility

In the case study above, John also enjoyed a varied caseload on his fieldwork placement. Seeing a variety of clients is one way to introduce to John the service opportunities that his health profession could offer as well as a career path if he wants to specialise in any particular area or client condition. Developing a strong interest in a particular area also adds to the excitement of going to work. Opportunities to work autonomously and to take on more responsibility are influential in developing a positive attitude towards a practice setting (Crowe & Mackenzie 2002). Developing competencies in autonomous practice are optimally suited to final year placements.

FINAL WORD

While the workplace can encourage students to return through well thought-out orientation, social networks, variety of client caseload, opening students' eyes to the possibilities of their profession, not all factors can be controlled. For students who have family nearby or partners to consider, returning to work at a previous fieldwork placement is made much easier if they know what to expect. However, students without any previous connection to an area, geographically or socially, can be encouraged to return as health professionals in practice if the fieldwork experience has been enjoyable, well supervised and they develop a sense of community or belonging in that setting.

REFLECTION

WHAT WOULD YOU DO?

What would you do if you had a student, who you knew you would not employ as a graduate, but who starts to ask about possible future positions?

SUMMARY

The student's experience of placements in the latter part of their degree can be very influential as to where that student chooses to practise. Rural placements have been used as a strategy to provide a positive experience to students and to encourage them to consider choosing a practice setting in a non-metropolitan region. The quality of the fieldwork experience, and hence the potential influence on student choices of where to work as a new graduate, is strongly influenced by the quality of the supervision and the fieldwork experience during the placement. Supervisor training is recommended as a way not only to build capacity in the health professions of a region but also to strengthen the possibility of a positive student experience on fieldwork.

Discussion questions

1 What influenced my choice of practice setting?

2 Which fieldwork placement experience was the most influential on my decision on where to practise?

Portfolio development exercise: Strategies for recruiting

- Gather together a number (around 10) of advertisements for vacant positions in your professional area from the press, websites or other sources relevant to your work area (for example, some government departments or professional bodies have weekly vacancy bulletins or web pages). From these, which would you apply for? Identify what it is that the agency is saying or offering that attracts you. Likewise for those you would not be interested in applying for, list the factors that influenced your decision.
- Reflect on this in relation to fieldwork opportunities in your agency. List ways in which could you build in some of the strategies or aspects that are likely to support recruitment into your fieldwork placement. For these choose three to five that seem most important based on the material presented in this chapter and your knowledge of your agency.
- Write down some concrete goals around these and include actions and timeframes to ensure that you incorporate these aspects into your fieldwork program. Review these yearly—hopefully by asking for feedback from graduates you have employed as to why they applied for a position in your agency.

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PART 3 CHECKLIST

TRANSITION TO PRACTICE

The following points have been collated from Part 3 of the book. This checklist is organised under the competencies of: professional behaviour, ethical behaviour, communication, knowledge of discipline-specific assessment and treatment, lifelong learning and interprofessional practice (collaboration and working in teams).

What professional and discipline-specific knowledge did you gain in your own clinical fieldwork placement experience? Reflect on your fieldwork experiences.

- ❑ What was helpful to you?
- ❑ What was not helpful to you?

You become the supervisor

The competencies of: lifelong learning, professional behaviour, interprofessional practice, communication, and ethical practice are all involved in beginning work

- ❑ To orient to my first job, I have reflected on what I did to orientate myself to my fieldwork placements:
  - ❑ What strategies did I use to become familiar with new environments?
  - ❑ Did I need a map initially to help me find my way around?
  - ❑ How did I remember the names of all the staff who were in my immediate and wider working environments?
  - ❑ Did I use a computer-based calendar or reminder system to help me keep appointments, schedule sessions and so forth?
- ❑ Action: If these and other strategies worked for you when you were a student, use them again in your first job.

Starting out in supervision

Being a fieldwork educator includes the competencies of: professional behaviour, ethical behaviour, communication, knowledge of discipline-specific assessment and treatment, lifelong learning and interprofessional practice.

Lifelong learning

- ❑ Reflect on what learning and teaching style best suits you.
- ❑ Action: Plan your continuing professional development around your own identified learning needs.

Communication

- ❑ Action: Your understanding of the need for using learning and teaching styles that best suit an individual will be of great value when you work with fieldwork placement students. You will be aware that each student has his or her own learning style.

Discipline-specific knowledge, professional behaviour and communication

As a new fieldwork educator, you will be required with your student/s to:

- ❑ articulate your professional practice
- ❑ explain your conceptual maps of the interrelations between theory and practice
- ❑ explain your organisational setting and policy environment
- ❑ demonstrate various professional skills and attributes.

Professional and ethical behaviour and communication

As a new fieldwork educator you can help your student to:

- ❑ understand the purpose of supervision
- ❑ take an active role in negotiating a contract with you
- ❑ prepare for sessions
- ❑ engage in active participation and be willing to be open and reflective in each supervision session.

As a fieldwork educator I am becoming aware of the different phases of supervision:

- ❑ establishing the relationship
- ❑ consolidating the relationship
- ❑ closure and evaluation

Professional behaviour and interprofessional practice will impact on recruiting students to my workplace. In my role as a fieldwork educator it is important to:

- ❑ orientate the student to the organisation and the staff
- ❑ connect the student to social networks (such as sports teams) if needed
- ❑ check on accommodation (if needed)
- ❑ provide a variety of clients
- ❑ support the student in the student's learning.

Legal Issues

Richard Ingleby

INTRODUCTION

This appendix discusses three legal issues arising out of the relationship between fieldwork placement students and the university at which they are studying:

the obligation of the university as an employer to provide a safe workplace
the liability of the university for acts of negligence committed by fieldwork placement students
the confidentiality of information obtained by and about placement students.

These issues are discussed in the context of placements in: hospitals, community-based service provision and client-health student interaction. The purpose of the discussion is to make you and those responsible for you aware of potential legal issues relating to fieldwork placements, so as to reduce the risk of illegal and/or inappropriate behaviours and improve the quality of the fieldwork placement experience.

THE OBLIGATION OF THE UNIVERSITY AS AN EMPLOYER TO PROVIDE A SAFE WORKPLACE

Universities are employers of people. Employers have many legal duties towards their employees. Most of those duties are now part of legislation. In Victoria, section 21(1) of the *Occupational Health and Safety Act 2004* (Vic) ('the Act'), which has equivalents in other jurisdictions, provides that:

> An employer must, so far as is reasonably practicable, provide and maintain for employees of the employer a working environment that is safe and without risks to health.

The definitional section of the Act provides that an employer is a person who employs one or more other persons under contracts of employment or contracts of training. The combination of these sections means that a university has a responsibility to make sure that its fieldwork placement students have a safe working environment.

The lack of any precise definition of concepts such as 'so far as is reasonably practicable' and 'safe and without risks to health' means that the interpretation of the duty is a practical problem from the perspective of the university. The High Court has held, in *Miletic* v *Capital Territory Health Commission* (1995) 130 ALR 591 per Brennan, Deane, Dawson, Gaudron and McHugh JJ at 594, that:

> the question whether a reasonable person would take steps to avoid a foreseeable risk of injury to another is to be answered by balancing 'the magnitude of the risk and the degree of the probability of its occurrence, along with the expense, difficulty and inconvenience of taking alleviating action and any other conflicting responsibilities' which may exist.

The university therefore needs to consider:

- the risks of harm to which its fieldwork placement students might be exposed
- how likely it is that such harm will occur
- the expense, difficulty and inconvenience of preventing the harm
- other conflicting responsibilities.

Clearly this is not a straightforward balancing act to achieve. One of the university's 'conflicting' responsibilities is to ensure the quality of the students whom it accredits by the award of a degree. If a university is going to accredit a social work student with a qualification, this necessarily imports a component of real-life experience. In social work, as in other health professions, there are vital training elements which can only be derived from experience of the real world.

Because books and lectures are not enough to provide practical experience, fieldwork placement students need real-life experience if their studies are to be of practical value. But the very reality of the real world includes exposure to danger. In taking the student to a setting other than, and less protected than, the university, fieldwork placement students will necessarily be exposed to risks, and also exposed to risks whose management is less susceptible to the control of university processes. Indeed, one of the most important purposes of fieldwork placements is to give students experience in relation to such risks.

If a fieldwork placement student suffers injury while on a placement, then a legal question might arise as to whether the university has fulfilled its duties:

- to take reasonable care to provide a safe system of work
- not to expose the student to an unnecessary risk of injury.

HOSPITAL SETTINGS

In a hospital there are risks of infection. It would clearly be unreasonable to expect a university to ensure that a hospital fieldwork placement student was only brought into contact with healthy people. But the duty to prevent harm would cover the need to ensure that a fieldwork student was properly educated as to the nature of the risks and preventive measures before entering the hospital setting.

COMMUNITY-BASED SERVICE SETTINGS

With community-based service provision, students will be brought into contact with people who may have psychiatric conditions and/or issues relating to drug and alcohol abuse. Here there is a risk of the student being physically attacked. In order to fulfil its duty to prevent harm, the university might require that fieldwork placement students not be left alone with clients of such services. The university might also require the community-based service to have protocols in place to reduce the risk of such harms and to provide strategies in the event that such harms eventuate. Even if the university does not require the community-based service to have protocols, the community-based service is itself the employer of its own employees, and as such has a duty to provide a safe workplace. This duty would extend to fieldwork placement students, because it is clearly foreseeable that such persons would come into contact with the clients of the service. The community-based service could hardly argue that it was unaware of the risks posed by the nature of its clients, as these risks are likely to be the rationale for the existence of the service in the first place. If the community-based service program's protocols were more stringent than university requirements, this would hardly be a cause for concern; but if they were less so, then the university should be reluctant to allow students to spend time in such fieldwork placements.

As is the case with hospital-based placement, the existence of procedures designed to minimise risk would impose a duty on the university to ensure that students were aware of them.

CLIENT–HEALTH PROFESSIONAL INTERACTIONS

In the setting of client–health professional interaction, the risk of physical attack remains, although the likelihood of the harm might be lower. However, settings that involve more intimate and one-on-one interactions involve risks of sexual and racial harassment in a context of power imbalance between the professional and the fieldwork placement student. The key point here is not so much that the university would be liable for every such incident; rather, if the university ever became aware of any particular professional's propensity for harassing behaviour or comments, there would be a duty to ensure that students were not exposed to that behaviour. So if a student reported that a particular health professional made comments about 'some sort of Asian thing' or seemed too intimate in his or her interactions with the student, then the university would be negligent if it exposed subsequent students to that sort of behaviour, even if it were not liable for the first incidents.

THE LIABILITY OF THE UNIVERSITY FOR ACTS OF NEGLIGENCE COMMITTED BY FIELDWORK PLACEMENT STUDENTS

The university may be legally liable for acts committed by students who are on fieldwork placements. A student who is on a placement can be seen either as the agent of the university or the employee of the university. By reason of the doctrine of *vicarious liability*,

the university will be liable for the losses to a third party caused by the negligence of a student. It is immaterial whether the third party is a client of or a representative of the fieldwork placement setting. The doctrine of vicarious liability imposes a legal obligation on the university, even if the university is not implicated in or even aware of the act that gives rise to the action in negligence against the student. All that is required (although there is much uncertainty at the outer limits of the meaning of the phrase) is that the negligence be in the course of the student's fieldwork placement.

One practical implication of the doctrine of vicarious liability is that a person who suffers loss by reason of a fieldwork placement student's negligence may prefer to pursue legal action against the university, because the university has 'bigger pockets' from which to fund an award of damages and costs.

In hospitals, fieldwork placement students are unlikely to be directly involved in the provision of treatment. This means that they are unlikely to be in a position where they can cause damage by the negligent provision of treatment. But a university that wants to ensure that it minimises the risk of vicarious liability should ensure that its fieldwork placement students are aware that they should confine their activities to the sphere of their placement.

In community-based service fieldwork placements, the student is perhaps equally unlikely to cause loss to the clients of the service. But an issue of vicarious liability could easily occur if, for example, the student drove a client from one place to the other and in the course of that journey caused loss to the client and to other members of the public by negligent driving. In such circumstances the victims of the negligent driving would have a claim against the university.

In the case of a fieldwork placement with a client–health professional, perhaps the likeliest act of negligence is a negligent disclosure by the student (as discussed in the next section of the Appendix) that breaches the confidentiality of the client–health professional setting. In such circumstances, the client would have an action in negligence against the university.

The existence of vicarious liability is an incentive for universities to ensure that its fieldwork placement students are properly briefed before their placements.

THE CONFIDENTIALITY OF INFORMATION OBTAINED BY THE STUDENT ON PLACEMENT

There are various legal ways in which an obligation of *confidentiality* may attach to information obtained by a student in the course of their fieldwork placement. The principles of vicarious liability discussed in the previous section mean that the breach of the obligations may create legal consequences for the university as well as the student.

Of most direct relevance for students who are in hospital fieldwork placements are statutory provisions that make information confidential. For example, section 141(2) of the *Health Services Act 1988* (Vic), which has equivalents in most other Australian jurisdictions, creates a statutory obligation of confidentiality by making it a criminal offence for a 'relevant person' (which would include a fieldwork placement student) to divulge information that would identify a patient or recipient of health services, unless the disclosure falls within a narrowly prescribed band of exceptions. This statutory provision was not completely new,

as there were long-standing provisions of the *Evidence Act* precluding doctors from giving evidence about their patients without the patient's consent. The Victorian Supreme Court has given section 141(2) an interpretation to protect patients. In *PQ* v *Australian Red Cross Society* [1992] 1 VR 19 at 29, McGarvie J held that the intention of the section was:

> to confer on patients a legal protection of the nature of that which in ordinary speech would be referred to as 'patient confidentiality' To render a protection of confidentiality to a patient real, what needs to be protected from disclosure in the vast majority of cases is the information that has been obtained in respect of the patient, not merely the information that the person was a patient.

The *Health Records Act 2001* (Vic), as its title suggests, makes specific provisions that are designed to

> promote fair and responsible handling of health information by–
>
> (a) protecting the privacy of an individual's health information that is held in the public and private sectors; and
> (b) providing individuals with a right of access to their health information; and
> (c) providing an accessible framework for the resolution of complaints regarding the handling of health information.

These provisions include the power to order 'that the complainant is entitled to a specified amount, not exceeding $100,000, by way of compensation for any loss or damage suffered by the complainant, including injury to the complainant's feelings or humiliation suffered by the complainant, by reason of the act or practice the subject of the complaint'.

The *Health Act 1958* (Vic) contains a specific provision in relation to the privacy of an HIV-infected person by stating that (in section 128):

> A person who, in the course of providing a service, acquires information that a person has been or is required to be tested for HIV or is infected with HIV, must take all reasonable steps to develop and implement systems to protect the privacy of that person.

There are equivalent provisions in the *Mental Health Act 1986* (Vic).

Students with community-based services may be on fieldwork placement pursuant to a contractual arrangement. It may well be that the terms of this contract include an obligation of confidentiality within other terms, such as those making provision for matters such as insurance and regulation of mutual responsibilities. If such a contract also contains a requirement that fieldwork placement students maintain the confidentiality of information derived by them in the course of their placement, then the fieldwork placement student's breach of confidentiality will be a breach of the contract. Such a breach of contract could give rise to a claim for damages (against the student and the university), in addition to other forms of relief to limit the disclosure of the confidential information.

Students who are in client–therapist fieldwork placements are perhaps less likely to have a contractual source of an obligation of confidentiality. But the laws of equity might create a 'breach of confidence' action against the student and the university if a student discloses confidential information without the authorisation of the client/patient. As mentioned in the previous section, another possible source of an obligation of confidentiality is the law of negligence. If, as would normally be the case, the fieldwork placement student owes the

client a duty to keep information confidential, then the disclosure of such information will be a breach of that duty of care which could give rise to an action for damages (against the student and the university) if the client suffers foreseeable harm by the disclosure.

It is not difficult to conceive of circumstances in which a fieldwork placement student makes a negligent disclosure or breaches a confidence deriving from his or her experience in the client–health professional setting. I say this because of personal experience, and also because I am confident that my personal experience is not atypical. The extent to which passengers on public transport (and invariably this means crowded public transport where notions of privacy are fanciful) engage in the practice of 1) reading documents to which obligations of confidence applies or 2) discussing 'interesting' features of their day might be reduced if the people whose confidences were being breached became aware of the breaches and took legal action in relation to them.

As a barrister I once agreed to the briefing solicitor's request to send along a work experience student. When I informed this student that it was very important that everything she saw or heard remained confidential, she assured me that she was aware of how important that was. She was less assured when I told her that I had heard her talking to her friend about her previous day's experiences when we were travelling on the same train the previous evening. I have also heard people on trains discussing their legal proceedings in circumstances where they cannot possibly have known whether the people around them were acting for the other parties to the proceedings. Confidentiality means confidentiality. Students need to be aware of this. You cannot go wrong if you simply adopt the practice that you do not discuss your professional practice except in the course of your professional interactions.

SUMMARY

Legal issues arise from students undertaking fieldwork placements in hospital, community-based and client–health professional settings. Three issues were discussed which were: the obligation of the university to provide a safe workplace or learning place for students on fieldwork placements; the liability of the university for negligence of a student; and confidentiality. There are areas where you could have legal action taken out against you: such as, discussing cases outside of your fieldwork placement and being negligent in your behaviour with clients. Learning professional behaviour on your placement also covers taking into account ramifications of your actions towards clients and other professionals.

REFERENCES AND FURTHER READING

For an organised statement of relevant legal principles see Halsbury's *Laws of Australia* (2008). LexisNexis, Sydney.

In relation to occupational health and safety more specifically, see Johnstone, R. (2004). *Occupational Health and Safety Law and Policy: Texts and Materials*. Law Book, Sydney.

In relation to principles of the law of negligence see Luntz, H., Hambly, D., Burns, K., Dietrich, J. & Foster, N. (2008). *Torts: Cases and Commentary*. LexisNexis, Sydney. See also Mendelson, D. (2007). *The New Law of Torts*. Oxford University Press, Melbourne.

Glossary

Aboriginal and Torres Strait Islander (ATSI) people

The people who occupied continental Australia, Tasmania and the Torres Strait Islands before the arrival of Europeans in 1788.

Aboriginal community-controlled health services

Primary healthcare services initiated and controlled by local Aboriginal communities to deliver holistic, comprehensive and locally appropriate healthcare (the term is understood to include both Aboriginal and Torres Strait Islander people).

Aboriginal health workers (AHWs)

Aboriginal and Torres Strait Islander healthcare workers, some with no clinical training, and others providing advanced clinical care to Aboriginal people in emerging areas of need, such as haemodialysis and midwifery.

Accommodation

A major problem faced by students investigating rural fieldwork placements; matters to be investigated before taking up a placement include cost (and possible subsidisation), cleanliness, service and food provision, air-conditioning, computer access, sharing and leisure.

Acute care

The treatment of patients for a relatively short period of time for an episode of illness that is brief but that can be severe, in a hospital's emergency department or ambulatory care clinic, or in another type of facility for the purpose of short stay.

Acute hospital setting

The hospital setting where children can be seen as an inpatient or on an outpatient basis.

Administrative function

The function of employees involved in organisational policies or protocols.

Adult learning principles

Principles that recognise (a) that the adult learner is an autonomous learner and able to direct her or his learning; (b) that the adult learner brings life experience to learning,

which provides a valuable resource for new learning; and (c) new knowledge is directly applicable to real-life situations in the present rather than the future.

Alternative fieldwork or alternative placement

Fieldwork that offers the student a wide variety of learning experiences where service gaps have been identified by the agency that provides for the fieldwork placement.

Assessment

The measure of whether learning has taken place.

Assessment criteria

Since fieldwork cannot be assessed by exams or term papers, students need to show they are learning 'on the job', and that they are sufficiently flexible to take advantage of new situations. See Chapter 6 for the full range of fieldwork assessment criteria.

Autism spectrum disorder (ASD)

A diagnosis given to children who have difficulty with social interaction, communication and imaginative play.

Capacity

An individual's ability to make a specific decision (rather than the contribution made by a healthcare professional or organisation).

Child and family health nurse

A health professional working with mothers and children, whose scope of care extends from the antenatal period until the child is aged five years.

Chronic condition self-management program (CCSM)

A healthcare program that teaches participants how to better manage their chronic medical conditions, make informed decisions regarding their health and reduce their reliance on direct healthcare.

Clinical placement, education or practicum

Fieldwork placement in a hospital or clinical setting; however, some health students are placed in a work setting, school or other type of organisation; hence *fieldwork placement* is the preferred term.

Clinical reasoning

The systematic application of a process of reasoning to the data collection of clients; an important element of clinical competence.

Collaboration

To be able to work with others in a team and share knowledge and skills.

Communication

Usually of two types: (a) primary communication: between you and the patient or client; and (b) secondary communication: additional information gained by sharing information regarding the patient or client with other team members via medical files and by talking with the patient's or client's family or carer.

Community-building project work or community projects

A project in which fieldwork students can contribute their skills to a wide range of skills and disciplines, while bringing into effect their own special abilities.

Community neighbourhood program

A facility in the community, usually in a suburban house, where local community events are held that support the local community.

Competent self-directed learner

A competent self-directed learner is more likely to be successful in alternative fieldwork placements. This is a student who is aware of the boundaries of their own profession and who can self-manage time and learning tasks.

Confidentiality

During fieldwork protects clients' rights to privacy and applies to all healthcare providers, whether they are professionals or students. It is an important issue, since private information is shared with other members of the care team to provide optimal care.

Consulting therapist

A therapist who visits schools, but who is often given very limited time to assess and establish recommendations for the child in school settings.

Continuing professional development

Opportunities for professional development available to students after graduation; one stimulating form of continuing professional development is to become a fieldwork educator to new students.

Continuity of care

The experience of care where various providers know what has happened before, agree on a management plan and guarantee care into the future.

Conventional fieldwork placements

Those placements where students have a fieldwork educator from the same profession, and placement occurs in a setting where that profession has had a presence for many years.

Core business

The core business of a profession is to define and assure standards of practice (including qualifying education) in the interests of the community, while concurrently advancing the standing of the profession within the community in the interests of the members of that profession.

Critical incident analysis

A learning method, based on *reflection* about a specific incident, using the following steps: (1) a description of the incident and those involved; (2) a description of the outcomes of the action for each involved in the incident; (3) a reflection on the process, naming the types of knowledge or experience that informed the actions, the skills used and the theories underpinning the actions; and (4) naming the learning from the incident, such as discipline-specific theory and knowledge; professional values and ethics; skills; personal beliefs and assumptions.

Critical reflection

The direction of health practice, based upon the questioning and challenging of knowledge generation, aimed at changing situations based upon a greater appreciation of the political and potentially emancipatory aspects of those situations. The thinking process of analysing and re-evaluating experiences and questioning outcomes.

Cultural competence

The ability to relate effectively with individuals of different cultural backgrounds.

Determinants of health

Factors associated with the health of individuals and communities, such as individuals' characteristics and behaviours, environment, genetics, income, level of education and social relations.

Digital literacy

Digital literacy represents a person's ability to perform tasks that include reading and interpreting media (text, sound, images), understanding and reproducing data and images through digital manipulation, interacting with others using language appropriate to the media, and evaluating and applying new knowledge gained from digital or online environments, using a computer.

Digital technology

Technology to do with computers, internet and cyberspace.

Discipline-specific knowledge or skills

Knowledge or skills that are specific to a particular profession.

Doughnut principle

A model for understanding the roles and responsibilities of those working in health and human services, especially when supporting someone with a disability through a decision-making process. The doughnut (see Chapter 12) has three concentric circles: (1) core responsibilities; (2) situations in which professionals have responsibility, but which require creativity and sound judgment; (3) aspects of a service user's life that are not the paid responsibility of health professionals, such as making moral decisions.

Duty of care

The obligation of a professional to adhere to an adequate standard of care while carrying out activities that could potentially be harmful.

Educative function

The objectives of educative supervision are to promote professional competence, develop skills and understanding about practice, make links between theory and practice, and enable you to assess your abilities using a mutual process of giving and receiving feedback about performance.

Emotional intelligence (EI)

The ability, skill or capacity to identify, assess and manage emotions, whether they are personal, of others or of groups.

Entrepreneurial

Health professional in private practice, running a small business, who is therefore dependent for his or her income on fees paid by clients.

Evidence-based approach

The systematic search for, and critical appraisal of, the most relevant evidence, combined with clinical expertise and client preferences and values, to answer a fieldwork question.

Exclusion

Broad social exclusion of Indigenous Australians.

Experiential learning

A series of actions, such as observation and reflection, that assist in establishing meaning from direct experience.

Family-centred care/practice

Healthcare practice that involves patients/clients and their extended family in decision-making and fosters partnerships between the patient/client and family and the professional(s).

Family services coordinator

The primary person responsible for the organisation of additional services, such as seeking funding and organising respite and family meetings.

Fieldwork

The placement of students in professional fields where they can gain hands-on experience before graduating; it (a) can occur at different levels of courses; for example, expectations for fieldwork placement at first year are very different from those required in a final year placement; (b) can occur in a variety of settings that have differing expectations; and (c) has specific requirements imposed by some professions.

Fieldwork education

A program of education of students undergoing fieldwork, which includes such aspects as students' roles; responsive and trend-setting practices; service enhancement, health promotion and program development; constructive peer evaluation and reflective practice.

Fieldwork education supervisor

The person who provides the same type of service to upcoming students as one's supervisor provided to oneself; including setting clear learning goals and expectations; providing feedback (formal and informal); facilitating self-directed learning opportunities; and undertaking an evaluation before the final evaluation to enable monitoring of progress.

Fieldwork educator

Professional in the field who supervises students in their placement settings (in situ). Also known as fieldwork education supervisors, field educators, fieldwork supervisors, clinical educators and clinical supervisors. This person can be an academic staff member from the student's university or educational institution. University staff

involved in fieldwork organisation, collaboration or liaison are clearly identified in the text as university staff members.

Fieldwork Learning Framework

The personal and professional resources and attributes, developed during fieldwork, that contribute to developing skills, knowledge and behaviours for professional practice.

Fieldwork placement

The location where a student is sent to learn how to put in practice skills already studied in coursework; also known as clinical placement, clinical practicum, clinical education and fieldwork experience.

Fieldwork placement agency

Organisation that agrees to provide an industry learning experience for a student.

Final fieldwork placement

The final placement undertaken by a student before final assessment.

Forcefield analysis

An analytical tool for weighing up pros and cons in decision-making, by listing all of the components integral to an issue and giving each a weight in terms of its impact on potential outcomes.

Generic role

A health professional takes on the role of family services coordinator, the primary person responsible for the organisation of additional services such as seeking funding and organising respite and family meetings.

Geriatric care (or geriatrics)

A branch of medicine or social science dealing with the health and care of old people.

Goal-setting

Decisions made about where you want to be, and how you might get there.

Good death

A dying person's support network as well as him/herself are assisted to make critical decisions about healthcare, place of death and to facilitate bereavement care for the family.

Good enough death

Generic skills of health professionals such as peer debriefing, reflective practice, self-awareness, client and family-centred care, empathic communication and self-management enable a health professional to assist clients in palliative care and their families to achieve a good enough death.

Government

The organisation, whether federal or state, that provides the funding sources for higher education as well as for large areas of the Australian community's health and human services.

Graduate

A health professional who has successfully completed the requirements of their degree and who is now applying for positions in the health workforce.

Health promotion

Within health this is the promotion of health and prevention in order to increase the quality of life for the patient/client and carer.

Horizontal partnerships

Stakeholder partnerships where expertise is shared between partners, and the relationship is acknowledged as symbiotic.

Host centre

Community centre where identified gaps in services are addressed by student-directed projects to enhance and build on an existing service.

Illness trajectory

The illness trajectory is the progression of the disease, and time. There are several phases which are treatment phase, palliative care phase, terminal phase and bereavement phase.

Indigenous health

The health status of the Australian Indigenous population. On all accounts the health status is below that of non-Indigenous Australians.

Indigenous health settings

Healthcare services aimed at increasing the capacity of non-Indigenous students to improve Indigenous health outcomes, contribute to service delivery to Australian Aboriginal people and develop partnerships between Indigenous and non-Indigenous organisations and universities.

Indigenous population

In Australia this refers to the Indigenous population, which is made up of Australian Aboriginal peoples and Torres Strait Islanders.

Individual professional

Individuals doing specialist work within health and human services, including occupational therapists, social workers, nurses, speech pathologists and physiotherapists.

Infection control

The measures that must be undertaken because patients are always at risk of acquiring infections in the healthcare environment because of lower resistance to infectious agents and an increased exposure to disease-causing microorganisms.

Information literacy

Information literate people recognise a need for information, determine the extent of information needed, access information efficiently, critically evaluate information and its sources, classify, store, manipulate and redraft information collected or generated, incorporate selected information into their knowledge base, and use information effectively to learn, create new knowledge, solve problems and make decisions.

Information management

Part of the knowledge transfer cycle where information management is made up of information discovery, information organisation and information processing. This then leads to knowledge transfer.

Information pack

This is a pack of information on the fieldwork placement or practicum for all stakeholders so that they understand the specific fieldwork-related roles, goals and expectations. For fieldwork educators this is information on the course that the student is undertaking and the university goals for the placement, and for the student this information is about the centre where they are undertaking placement.

Injured workers

Individual workers who can be returned to the workforce following a work-related injury, through the efforts of rehabilitation consultants, as defined by the guidelines of the relevant Act.

Inpatient

A person who receives services from health professionals when they are staying in a hospital.

Integrated fieldwork practice

Fieldwork practice that reflects the day-to-day and real-world dynamics of fieldwork placement.

Interdisciplinary team

The key unit within a person-centred care environment, which recognises the patient's or client's freedom to make his or her own decisions; with the patient or client at the centre of all care decisions.

Interprofessional education (IPE)

Program designed to help students from a variety of disciplines, who find themselves in the same team, to understand each other in order to avoid unnecessary misunderstandings that can cause team conflict and dysfunction.

Interprofessional learning (IPL)

A term used to describe interprofessional education (IPE) and interprofessional practice (IPP). IPE occurs when more than one profession learn together, collaborating to improve quality of care of clients and patients.

Johari window

A reflective tool designed to develop and enhance self-awareness. It takes the form of a diagram (see Table 5.4 in Chapter 5) that is divided into four panes or quadrants: open, blind, hidden and unknown.

Knowledge transfer

Knowledge transfer occurs with knowledge creation in context, knowledge translation in context and knowledge dissemination.

Learning in fieldwork

The interplay of a complex array of variables, which include students' knowledge, skills, attributes and dispositions; their capacity to manage time, tasks, themselves and others; reflective and clinical reasoning skills; a capacity to transform theoretical knowledge into practice; and the nature of fieldwork educator–student relationships.

Lifelong learning

The dynamic engagement of healthcare professionals with ideas, practices and people throughout their working lives. This also includes recognising cultural discomfort as a spur to embracing an opportunity for lifelong learning about one's own beliefs and misconceptions. Lifelong learning is a competency recognised by the health professions.

Line management

A student's immediate supervisor or boss.

Medicare

A national insurance program that provides health insurance coverage in Australia. In the context of this book, Medicare also refers to the USA system of health for over-65-year-olds.

Mental health

The successful performance of mental functions, in terms of thought, mood and behaviour, that results in productive activities, fulfilling relationships with others and the ability to adapt to change and cope with adversity.

Midway assessment or midway feedback

An assessment halfway through a placement that gives students an opportunity to learn from both successes and difficulties before facing final assessment.

Midwifery

A nursing speciality that focuses on mothers and their babies and recognises the woman's individual needs, aspirations and expectations, encompasses the needs of the baby, the woman's family and other people important to the woman, and follows the woman across the interface of community and acute settings.

Mindfulness

Mindfulness is the extension of reflection where the practitioner is aware of their biases and prejudices and can cast these aside to be nonjudgmental in decisions. Experience, skills and clinical reasoning are seen as an art and a science.

Multiple language groups

The variety of group languages, histories, beliefs, practices and needs that may be found in any healthcare setting.

Narrative inquiry

The investigation of evidence provided by stakeholder narratives about personal experience, including stories told by students, fieldwork educators, clients and university educators.

Negotiation

Advice provided by healthcare consultants, often when forging agreements between injured workers seeking a suitable return-to-work plan and employers prescribing the limited options available.

Neonatal intensive care unit (NICU)

A specialised hospital unit that provides care for extremely premature babies, and babies who require surgical intervention.

Occupation Wellness Life Satisfaction (OWLS) program

A program designed to provide sufficient, relevant and valuable fieldwork opportunities for occupational therapy students within regional Victoria (see Chapter 7).

Occupational rehabilitation

A program aimed at returning injured workers to work in a capacity that is in line with their functional and cognitive capacity.

On placement

The measures and protocols that students should know before arriving at a new placement (see Chapter 1).

Online identity or profile

A person's identity on social media and other media in digital technology. This refers to how a person is portrayed through such media. The development of a professional online profile that is potentially visible to future employers, clients and colleagues.

Online technology

The internet is the greatest source of online technologies. Through online technology sharing of information and knowledge can occur on a global level.

Orientation

The supervisor's introduction of on-placement students to facility settings and specific placement characteristics, such as caseload, in a way that may encourage students to return after graduation.

Outpatient

A person who comes into the hospital to see a health professional but who is not staying in the hospital.

Pace of work

In the hospital setting, the combination of rapid patient movements and the variety of tasks that must be accomplished in a short time.

Paediatrics

The assessment and treatment of children who have a range of neurological, developmental, genetic and medical conditions that have an impact on their ability to participate in everyday situations.

Palliative approach

In the palliative approach to care, the health professional does not aim to cure the patient but to provide best quality of life for the dying person and the person's family before a dignified, peaceful and timely death.

Palliative care

This type of care is generally delivered to people who have a disease or clinical condition that is progressive and there is no prospect of a cure.

Patients and clients

The people the student is assessing, treating, interviewing or working with. Both terms are used throughout the book, as some case studies refer to clinical situations (where *patient* is used) and other case studies refer to nonclinical situations (where *client* is used).

Peer fieldwork performance evaluation

Evaluation of fieldwork students, in pairs or small groups, providing constructive student-driven feedback, aligned with specific learning goals of one's peers.

Personal attributes

The qualities that the student brings to the fieldwork placement, including traits such as age and gender, learning style, cultural and family background and the presence or not of a specific health condition or disability.

Personal authority

The personal quality that stems from an individual's demeanour and ability within professional relationships to exercise competence and enforce decisions. Too much reliance on authority can lead to conflict in supervision, while too little exercise of legitimate authority can lead to collusion and the collapse of safe practice.

Person-centred care

A patient's or client's freedom to make his or her own decisions; it is a holistic view, with the patient or client at the centre of all care decisions.

Person-centred risk assessment

This assessment guides decisions on risk to a vulnerable individual by consideration of their safety and happiness. It was developed by Kinsella (see Chapter 12).

Perspective transformation

The alteration of a student's or educator's viewpoint, such that the person experiences a changed and more accurate view of his or her performance.

Pharmaceutical Benefits Scheme (PBS)

The system that has been created by the Australian government to provide timely, reliable and affordable access to necessary and cost-effective medicines.

Placement contract

In fieldwork education, the document that addresses the specific expectations between the student, the supervisor and the education institution, including practical matters, the timeframe of the placement, agency conduct rules, arrangements for supervision and backup during the absence of the fieldwork educator.

Police record check (PRC)

One of two certified documents (the other is the *Working With Children Check*) that students must complete and submit before the beginning of fieldwork placements each academic year. Without a PRC, students may not be granted permission to undertake fieldwork placement.

Postmodernist perspective

The learning perspective that challenges the *modernist* understanding of knowledge: rather than understanding knowledge from only a theoretical perspective, postmodernists incorporate other types of knowledge generated by reflecting on personal experience and culture.

Practice-reflection–theory-reflection process

The process by which students can use a number of critical reflection tools, including critical incident analysis, journal keeping, think sheets and narrative records, leading to new insights or perspectives. *See also* Johari window.

Pre-fieldwork placement

The preparation that a student undertakes when preparing for placement.

Private practice

An autonomous, entrepreneurial and possibly lucrative health service provider business, which is established through the investment of capital and resources, and usually involves going into debt before an income can be derived.

Private practitioner

Health providers who own and run their own business in their discipline-specific profession.

Profession

The collective efforts of each specific work role undertaken by individual members of the health and human services workforce.

Professional authority

The health professional earns this authority through credible practice of knowledge and skill.

Professional standards and image

Those aspects of students' behaviour and appearance that allow fellow health professionals to evaluate performance and work successfully together within the placement.

Professional stereotypes

These are preconceived views of a person's characteristics and attitudes based solely on the knowledge of that person's discipline and nothing more.

Readiness to learn

Students' readiness to use the experience of success or failure in a fieldwork placement as a catalyst to alter perceptions of themselves or their worldview.

Reflection

A student's systematic consideration of fieldwork experience (positive and negative feelings) and the transition experience of moving into the workplace as a qualified health professional.

Reflective and reflexive practice

Other terms used for reflective practice are: critical reflection; reflective thinking; reflective learning; metacognitive reflection; and, mindfulness. Reflective practice, at its basic level, is the thinking and problem solving that we do in our everyday lives.

Rehabilitation provider

A health professional provided in most workplaces to meet with injured workers, the workers' supervisor and/or the return-to-work supervisor in order to assess the specific requirements of the injured worker, health practitioners, insurers and the employer.

Remote and rural health settings

Healthcare placements scattered widely throughout the hinterland of Australia, often forced to deal with workforce and facility shortages, but also providing intense social and healthcare experiences for students.

Return-to-work plan

A plan that is worked out, often with the healthcare workers as negotiators, to balance the interests of injured workers attempting to return to work, employers and other interested parties, such as insurers.

Role authority

This type of authority of the health professional is conferred by the organisation and the university.

Role-emerging fieldwork

Activities of students that demonstrate and communicate the potential of their professional role within the fieldwork place and the community it serves.

Royal Flying Doctor Service (RFDS)

A healthcare service, provided by pilots using small aircraft, that operates throughout remote areas of Australia.

Rural health practice

Health practice that occurs outside of a major metropolitan city. Usually service delivery is different but the need for high levels of knowledge and competence do not differ from city practice.

Self-assessment

The development by students of the ability to assess their own performance and reduce their dependence upon external forms of assessment.

Self-awareness

Students' awareness of their own biases, assumptions and prejudices, and the ability to set appropriate professional boundaries, sustain self-respect and strike a balance between working independently and interdependently when required.

Self-evaluation

This is the same as self-assessment.

Self-regulation

The ability to demonstrate skills in time management, conflict management, impulse control and management of stressful situations and strong emotions without becoming overwhelmed.

Social media

Online sites that support the maintenance of existing social networks, or help people connect with strangers who may share interests or activities, varying in the types of applications and communication tools they offer users, such as mobile connectivity, Facebook, blogging and photo or videosharing.

Stages model of supervision

The main levels of supervision exercised by fieldwork supervisors are (1) dependency; (2) fluctuation between dependency and greater independence; (3) proficiency and confident independence; and (4) professional autonomy.

Stakeholders

All those individuals and organisations who have something to contribute to or gain from any human activity. The health and human services profession includes such key stakeholders as universities, the government and individual professionals and students. Usually a partnership is formed that requires cooperation for a mutual benefit.

Stigma

'A mark or sign of disgrace or discredit' (*Australian Oxford Dictionary*). Stigma labels a person as not being 'normal', not 'fitting in' the broader community.

Stress

As experienced by many health professionals, stress is mainly the result of high workload, poor job satisfaction, lack of skilled supporting staff and inadequate training and supervision.

Superclinic

A health centre that provides a raised level of healthcare services within one centre, often offering longer opening hours and additional healthcare providers, and services such as onsite pharmacies, pathology labs and radiography.

Supervision

The process occurring within a professional relationship in which the fieldwork educator assists students to prepare for, reflect upon and explore practice issues in order to develop competence in their professional practice.

Supported decision-making

The principles that everyone is competent in making decisions, everyone communicates and we all seek support to make decisions from those we know and trust.

Supportive function

The supportive process is one where the fieldwork educator acknowledges and responds to your emotional needs and helps you to understand the processes of an event and the impact that event might have on you.

Teaching and learning

Teaching is transferring knowledge and creating environments where students learn. Learning is about understanding, critiquing and modifying knowledge, new or existing, in light of the contextual factors. This is where information starts to transform into knowledge and knowledge into wisdom.

Teamwork

The activities of a group of individuals who perform for a common purpose or goal and whose individual needs are of less importance than the needs of the group.

Terminal phase

When a patient who has been in palliative care reaches the stage of death.

Three Rs

Roles, rights and responsibilities (see Chapter 2).

Transdisciplinary team

A group of health professionals from a variety of disciplines, carrying out treatment suggested by another health professional.

Transition

The transition experience usually implies a journey from one destination to another (from student to healthcare professional) and the arrival at an endpoint—but healthcare professionals are usually considered to be always in the process of 'becoming': continually learning, relearning and/or unlearning old assumptions to develop new ways of working with people.

Triple helix partnering model

The interconnected spiral relationship between major stakeholders in any enterprise, where spirals are rarely equal, with one party acting as the core around which the others rotate.

Tutorial programs

Programs for students, delivered face to face or online, designed to support students as well as challenging them in skill development, practice reflection and professional thinking.

Unit

A subject within an entry level degree.

University

Facilities that deliver post-secondary education and advanced specialist knowledge through the integration of research and practice in health and human services.

Vertical partnerships

Partnerships between organisations, where one partner or group of partners acts as a consultant (commissioned expert) to others wishing to make changes in structure, functioning or methods of service delivery.

Vulnerable decision-makers

Adults with disabilities, such as developmental disabilities, psychiatric disorders and psychosocial difficulties, or neurological deficits, for whom the characteristics associated with their condition can affect decision-making.

Web 2.0

Online tools that have embraced the power of the internet to harness collective intelligence. The Web 1.0 internet changed from being a unidirectional repository into Web 2.0, with the ability to search and download information as a multidirectional virtual environment, where people can interact with each other, build networks, collaborate and share ideas, form questions, give information and create communities around topics of shared interest.

Woman-centred care

Care that focuses on the woman's individual needs, aspirations and expectations, rather than the needs of the institution or professionals; and recognises the need for women to have choice, control and continuity from a known caregiver or caregivers.

Workplace practice

Workplace-based or work-related services provided to employers, insurers and other stakeholders, including services provided to an individual seeking employment or currently working.

Workforce recruitment

The graduate's application for a position, hoping to be recruited to the position. Workforce recruitment is important in both metropolitan and rural settings, and its success often depends on a student's positive placement experience.

Working With Children Check (WWC)

One of two forms (the other is the *police record check (PRC)*) that students must complete satisfactorily, and provide certified copies of, before setting out on most fieldwork placements. The check is required once every five years.

Work-integrated learning (WIL)

A term synonymous with *fieldwork* or *practicum*, which has been defined by the Australian Learning and Teaching Council as 'an umbrella term for a range of approaches and strategies that integrate theory with the practice of work within a purposefully designed curriculum'. As such, WIL encompasses more than just fieldwork placement.

Workplace literacy

The sets of skills, attitudes and behaviours required to practise competently in any field or job.

Workplace rehabilitation

The healthcare process that plans, in coordination with a clinical team, to enable people to return to work after an injury, including the provision of appropriate aids and accommodation, and assisting in accessing disability benefits as needed.

List of Useful Websites

All Things Socialwork: http://socialworkpodcast.com

Australian Bureau of Statistics, *Population Projections, Australia, 2006 to 2101*: www.abs.gov.au

Australian Department of Health and Ageing: www.health.gov.au

Australian Institute of Health and Welfare (AIHW)—Publications: www.aihw.gov.au/publications

Australian Federal Police: www.afp.gov.au/what-we-do/police-checks/national-police-checks.aspx

Blogger: www.blogger.com/start

Bloglines: www.bloglines.com

CNET Podcast Central: www.cnet.com/podcasts

Comcare: www.comcare.gov.au

Commoncraft: www.commoncraft.com

CRS Australia: www.crsaustralia.gov.au

Department of Justice: www.justice.vic.gov.au/workingwithchildren

Department of Health: www.dhs.vic.gov.au

Department of Human Services: www.dhs.vic.gov.au

Facebook: http://facebook.com

Get a Note from Your Doctor: www.ganfyd.org

Google Documents: http://docs.google.com

Google Reader: www.google.com/reader

Healthcare Blogger Code of Ethics: http://medbloggercode.com/the-code

Health Evidence Search Wiki: http://healthevidencesearch.pbworks.com

HONCode: www.hon.ch/index.html

How to Create a Podcast: www.how-to-podcast-tutorial.com

MedReader: www.medreader.com

MediaWiki: www.mediawiki.org/wiki/MediaWiki

Midwives and Second Life SLENZ project: http://sarah-stewart.blogspot.com/search/label/second%20life

MyCareer: www.mycareer.com.au

MySpace: www.myspace.com

National Indigenous Health Equality Summit in March 2008: www.hreoc.gov.au/social_Justice/health/targets/index.html

Ning: www.ning.com

Office of the Victorian Privacy Commissioner: www.privacy.vic.gov.au

PB Wiki user manual: http://pbwikimanual.pbwiki.com

Podcast.com: http://podcast.com

RSS in Plain English: www.commoncraft.com/rss_plain_english

Second Life: http://secondlife.com

Self-directed learning modules on cultural awareness and cultural competency for health professionals: www.nccccurricula.info/modules.html

Top educational locations in Second Life: http://healthcybermap.org/sl.htm

Victoria Police: www.police.vic.gov.au

WebCite: www.webcitation.org/5aDEkONrK

Wordpress: http://wordpress.org

YouTube: http://Youtube.com

Zoho Writer: http://writer.zoho.com

STATE POLICE

New South Wales Police: www.police.nsw.gov.au

Queensland Police: www.police.qld.gov.au

South Australia Police: www.sapolice.sa.gov.au

Tasmania Police: www.police.tas.gov.au

Victoria Police: www.police.vic.gov.au

Western Australia: www.police.wa.gov.au www.checkwwc.wa.gov.au

PRIVACY

There are some individual sites but the commonwealth site has links to relevant state laws www.privacy.gov.au/law/states

Office of the Victorian Privacy Commissioner: www.privacy.vic.gov.au

Office of the New South Wales: Privacy Commissioner: www.privacy.nsw.gov.au/

Office of the Queensland Information Commission: www.oic.qld.gov.au/

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