The Best Practice Clinical Learning Environment Framework

Delivering quality clinical education for learners

VICTORIA State Government | Health and Human Services

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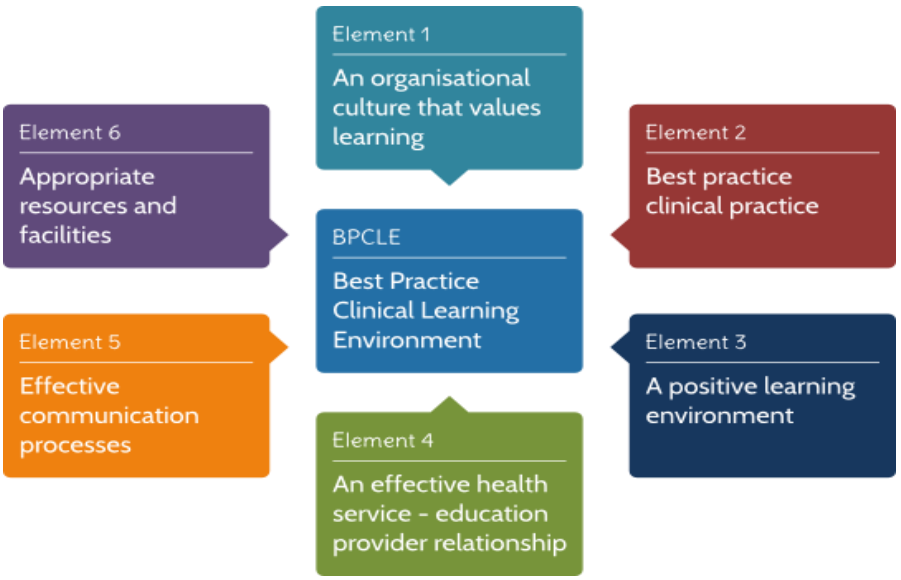

This document is available as a PDF on the internet at:
http://www.health.vic.gov.au/placements/resources/index.htm

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The Best Practice Clinical Learning Environment (BPCLE) Framework

1. Preamble

In May 2008, the Victorian Department of Health and Human Services (DHHS; the Department; formerly the Department of Health; DH) commissioned the Best Practice Clinical Learning Environments (BPCLE) project. The primary objective of that project was to develop a framework that would underpin consistency and excellence in clinical education and training across the state. This was part of a comprehensive strategy developed by the Department aimed at enhancing the capacity and quality of clinical education in medicine, nursing and allied health in Victoria. The ultimate aim is the creation of a sustainable health workforce and a health system that values the quality and competence of its workforce.

The framework was developed at a time when the Australian Government had responded to current and projected shortages in the national health workforce by dramatically increasing the number of Commonwealth-supported undergraduate places (CSPs) in medicine, nursing and allied health courses. Victoria campaigned successfully to secure a significant proportion of those places, resulting in substantial growth in the number of CSPs allocated to its entry-level health courses. The removal of caps on student numbers for most health professional courses by the Australian Government in 2012 further compounded this increase.

Although the increase is necessary to provide the pipeline of health professional graduates needed in Victoria in the coming decades, it represents a significant additional impost on an already over-burdened health service sector. In particular, the increase in CSPs results in a corresponding increase in the number of clinical placements required to appropriately train these students as undergraduates and then as early-graduates. Importantly, in developing strategies to deal with the increased numbers of health professional students and early-graduates, issues of quality go hand-in-hand with issues of quantity.

Despite the existence of some discipline and health service standards for clinical education and training, there is considerable variation in the quality of clinical education across the sector and, in some instances, even within individual health services.

The framework that was developed – based on data collected from hospitals, learners and university educators through case studies, surveys and interviews – was subsequently modified following consultation with stakeholders across the whole spectrum of health professional disciplines and health service settings. Two further projects added a resource kit and performance monitoring framework to the BPCLE toolkit and the whole package was piloted in a range of health services in 2012. Finally, an online tool was developed to assist health services with implementation.

The resulting framework is expected to improve clinical training experiences for all concerned, by informing policies, practices and behaviours. It is primarily targeted to the organisations that provide clinical education and training – principally health services – and is broadly applicable to a range of contexts, from primary care to acute health settings, as well as mental health, aged care and other social care settings. However, as discussed later in this document, stakeholders that are not health service organisations also have responsibility in the successful implementation of the framework.

Within health services, it is anticipated the framework will have different relevance to different categories of individuals:

- For CEOs, the framework will assist in setting objectives for HR services, performance targets for clinical divisions and in building and negotiating relationships with education providers. It also provides a risk management tool for addressing workforce sustainability.
- For Directors of Medical Services, Nursing and Allied Health, the framework will be useful in addressing teaching capability and quality of teaching.
- For individual educators and supervisors, the framework will guide self-assessment of their own contribution to clinical education and their own professional development needs.
- For learners, the framework will assist in shaping their expectations of their clinical education experience and setting standards for their own performance.

Implementation of the BPCLE Framework is expected to bring direct benefits to health services, including:

- Improvements to the clinical learning environment, resulting in better experiences for all learners and for staff involved in delivery of education and training.
- Efficiencies and improvements in clinical education activities and processes, resulting in less wasted effort by staff.
- Better relationships between health services and their education provider partners, resulting in more support for health service staff in the delivery of clinical education and improved teaching programs that produce work-ready graduates.
- Enhancement of the organisational learning culture, resulting in improved patient care and health outcomes.

In addition to these improvements relating to the delivery of clinical education and training, health services will derive a number of benefits from undertaking the processes associated with implementation of the BPCLE Framework, including:

- Organisational learning across and within health professions, leading to better relationships between disciplines and between staff.
- Increased awareness and understanding at all levels of the organisation of the costs and workloads associated with clinical education.
- Greater awareness of the processes associated with delivery of clinical education, which will in turn drive innovation and improvement.
- Empowerment of clinical education staff, through their involvement in review and planning activities and including them in the selection of appropriate indicators and objectives for targeting improvements.

High quality learning environments are a competitive advantage for any jurisdiction, both in relation to attracting health professional learners (who may subsequently be recruited to the workforce) and in recruiting senior clinical staff. This framework will assist jurisdictions, by ensuring consistently high quality clinical education across its health service sector. Importantly, the framework should be seen as a living document and future revisions of the framework should reflect the changing landscape of clinical education and training.

2. Using the framework

This framework is relevant to all those who deliver and are responsible for the provision of clinical education and training in health professional disciplines. Within health services this includes directors, coordinators and deliverers of education and training, as well as senior managers and administrators. This framework is also relevant to academic and clinical education coordinators and administrators within education provider organisations.

The framework provides guidance in relation to six key elements that are the underpinnings of a quality clinical learning environment. The framework is not intended to be prescriptive and acknowledges that many effective models of education and training exist, and also that discipline-specific requirements must be met. Instead, the framework presents a set of objectives and encourages individual health services to explore the most effective and appropriate mechanisms to achieve them. The accompanying BPCLE Resources Kit may provide a useful starting point and it is hoped that resources and expertise developed by individual health services to address these elements will be shared across the system, to enhance the overall quality of clinical education and training in all settings where it occurs.

To assist in implementing the framework, the BPCLE Performance Monitoring Framework (PMF) identifies a number of indicators for each element of the framework; the majority of these are suggested for use in internal health service monitoring only. The primary benefit of the indicators will be to allow health services to track their own progress over a period of time. Jurisdictions may also elect to nominate some of the indicators for external reporting, to allow jurisdiction-wide collection of data relevant to the quality of clinical education and training. For example, in Victoria, the Department has nominated a small number of indicators that may become part of funding and performance criteria, allowing future funding for education and training to be linked to both quantitative and qualitative indicators.

3. Scope

The original focus of this framework was on clinical education provided to learners in medicine, nursing and allied health disciplines, with particular emphasis on students enrolled in entry-level professional courses. In most instances, this involves an undergraduate bachelor level degree, although a growing number of courses are now graduate-entry and into the future, a number of courses will be graduate-entry courses at masters or doctoral level. This framework also applies to clinical education in the context of health professional courses offered by Vocational Education and Training (VET) sector institutions.

When the framework was first drafted, its other major emphasis was on clinical education and training for early-graduates. These are health professionals who are within the first 1–2 years of receiving their entry-level professional qualification.

More recently, it has been recognised that most aspects of the BPCLE Framework are also applicable to postgraduate, vocational and other specialist training, as well as ongoing professional development of more senior clinical staff (including up-skilling of practitioners returning to work after an extended absence). Indeed, entry-level and early-graduate clinical education is only the first stage of a continuum of skill and knowledge acquisition for health professionals.

4. Terminology

There is no single, agreed set of terms in relation to clinical education used across the spectrum of health professions. Indeed, even within professions, several terms may be used to refer to the same type of activity, reflecting different educational models used by different education providers. This is potentially problematic for a framework that is intended for use by all health professional disciplines. Even use of the term *clinical* is an issue for professions in which many aspects of the work do not involve seeing patients (or clients) in settings that would be classified as 'clinical'. Some health professions do not even involve direct interaction with patients or clients.

However, this framework is for clinical learning environments and a significant majority of health professions do involve direct interaction with patients or clients and therefore terms such as *clinical* and *patient/client* are used throughout the framework without further clarification. For those professions where this terminology is not applicable, it is recommended the terms be interpreted in their broadest sense and should be seen as being inclusive of discipline-specific variations or equivalents as appropriate.

Furthermore, it is acknowledged that some terms or concepts used in the framework may be more pertinent to some health service sectors than others. For example, the term *career structure* has relevance in large health services, but may have little relevance or applicability to small health services or clinics. On the other hand, another way of considering the 'career structure' concept is in relation to retention strategies for employees. Therefore, in those instances where a term used does not appear to be directly applicable, it is recommended that stakeholders either interpret such statements in a manner that is appropriate for their circumstances or simply disregard the statement.

Finally, no attempt has been made to define *educational skills* within this framework. Although some skills may be common to all clinical education contexts, other skills are unique to disciplines, settings, levels of learners or educational roles. The relative importance of specific skills is also likely to vary between groups. Stakeholders are therefore encouraged to define *educational skills* in whatever terms are most relevant to their circumstances and context.

With these general considerations in mind, several terms are explained below.

- **Clinical learning environment** – used in the broadest sense of the word 'environment', to encapsulate the range of factors that impact on the learning experience.
- **Clinical rotation** – used in the framework to denote the time spent by learners in particular clinical settings. This includes what are more commonly referred to as 'clinical placements' for entry-level learners, as well as 'rotations', 'specialty placements' and 'training programmes' for graduate learners. Clinical rotations may be of any duration, ranging from a few days to several months.
- **Early-graduate** – refers to an individual who has completed their entry-level professional qualification within the last 1–2 years. For example, this will encompass junior doctors employed in pre-vocational positions for postgraduate years 1 and 2 (PGY1 and PGY2; also referred to as Hospital Medical Officers), Registered Nurses and Midwives in Graduate Nurse/Midwifery Programmes (GNP/GMP), Enrolled Nurses in their first year post-qualification and allied health professionals in their first two years post-qualification (generally employed at Grade 1 level).

- **Education and training** – used interchangeably, although education is usually used in relation to structured courses for entry-level students, while training is a less structured activity that occurs post-qualification. In this framework, use of either term covers all possible meanings of both terms.
- **Educator** – used in the broadest possible context to refer to anyone who contributes to the education or training of another person. An educator may be a formally recognised or designated role, or it may be a clinician or practitioner who supervises a learner, although not formally designated as an educator. Different health professional disciplines variously use terms such as preceptor, supervisor, clinical educator, clinical associate, clinical facilitator, clinical teacher, clinical support, or mentor and the term educator should be taken to refer to whichever of these roles is applicable.
- **Health service** – used throughout the framework and refers to any health or social care setting, large or small, public or private. This includes aged care, private allied health clinics, general practice clinics, social welfare services, etc.
- **Learner** – used generically to refer to individuals undertaking education or training at any level.
- **Student** – refers to individuals enrolled in entry-level professional courses, regardless of the level of award.

5. Principles

This section sets out four principles that underpin the framework. Whereas the framework elements set out in Section 7 identify the aspirations or objectives of the framework, these principles define the assumptions on which the framework is predicated, as well as the limits of its application.

Principle 1: *Patient (or client) care is an integral component of quality clinical education.*

Patients/clients are central to the process of clinical education and are the most valuable resource in a clinical learning environment. However, this is a resource that must be neither overused nor misused and patient/client care should never be compromised by the need to provide learners with the most useful learning experiences. Indeed, observing and participating in the delivery of high quality care is a defining aspect of high quality clinical education. On the other hand, although patients/clients might be inconvenienced by the presence of learners, the interests of patients/clients – and of the community at large – are ultimately served by learners being educated about high quality care in a high quality clinical learning environment. Importantly, the clinical environment is a shared environment, with many groups having legitimate claims on its resources.

Principle 2: *Learning in clinical environments is an essential component of training all health professionals.*

Clinical education is an integral component of the training of all health care professionals because it provides a mechanism for clinical skills training, for professional socialisation and for integrated learning. Although some of the skills training and integrated learning can be achieved in other settings, for example using simulation or computer-based learning, there is no substitute for experience directly involving real patients or clients in clinical settings.

Therefore, the starting position for this framework is that clinical rotations are valuable activities that meet the needs of the system by assisting in achieving desired workforce outcomes. In general terms, the objective of clinical rotations is to develop domains of competence as well as attributes in the learner that will result in a professional who can contribute productively to the health care system. In this context, contribute productively comprises three main elements:

- Whether the individual works – that is, does the individual complete their training and join the health workforce to practice their profession?
- How the individual works – that is, does the individual have the necessary knowledge, skills and competency to practice their profession to appropriate standards and industry registration requirements?
- Where the individual works – that is, is the individual willing and able to practice their profession in an area of workforce need?

Principle 3: *Registration, accreditation or competency standards set down by professional bodies (where these exist) are the appropriate mechanism for ensuring that clinical education arrangements meet minimum standards for educational or training outcomes.*

This framework is not intended to replace, compete (or interfere) with the existing registration, accreditation and competency standards that apply to clinical education. Any conflict between the elements of this framework and professional standards must always be resolved in favour of the

professional standards. Furthermore, the review and revision of professional standards is a professional issue and is not within the scope of this framework. Similarly, if a clinical learning environment does not meet professional standards, it is a matter for resolution by the relevant professional body, and adherence to this framework does not obviate the requirement to meet professional standards.

This framework provides guidance to health services about creating a suitable environment for the delivery of clinical education and training. In this context, the framework should be viewed as building upon a base of minimum standards determined by each of the professional regulatory bodies.

Principle 4: *Many different models of clinical education and training exist and successfully produce health professionals of required competency and standard.*

In developing this framework, it has been assumed that organisations and their educational partners (universities, registered training organisations (RTOs) and professional colleges) are best placed to determine the educational model that most appropriately accommodates both curriculum requirements and resource constraints. Different models of teaching and educational supervision work better for some disciplines than for others and one model is unlikely to work equally effectively across all disciplines or even across different levels of learners within the same discipline. Furthermore, while this framework has been developed within (and therefore reflects) current educational paradigms, it is also acknowledged that educational trends shift over time and new educational models are continually being trialled and evaluated.

Therefore, this framework is intended to work across any model of clinical education and importantly, is intended to create the flexibility within health services to permit any educational model to be effectively employed.

6. Factors influencing clinical learning environments

This best practice framework for clinical learning environments is intended to provide stakeholders – most particularly health services – with guidance to inform policies, practices and behaviours that will improve clinical training experiences for all concerned. In this context, from the health service's perspective, factors that influence the delivery of clinical education can be categorised as internal or external.

- Internal factors are those factors controlled by the health service. These include: facilities, staffing levels and allocation of resources; educational skill level (and level of preparedness) of educators and/or supervisors; cultural attitudes towards education; enabling structures and policies; and communication practices.
- External factors are those factors not controlled by the health service that could influence the way clinical education is delivered. These include: levels of funding (from external sources, i.e. governments and education providers) provided for educational activities; key performance indicators; the availability of skilled staff in the community; the academic practices of education providers and the way learners are prepared for clinical rotations; the social, political and economic climate; accreditation requirements and professional standards, and the patient case load.

In reality, there is considerable interdependence between these two sets of factors, most particularly in the impact of external funding levels on internal factors such as staffing levels and allocation of resources. Nevertheless, the framework presented in the next section deals primarily with internal factors and provides guidance on how these can best be managed by health services to deliver the best possible clinical learning environment. A later section addresses the responsibilities of other stakeholders in this system to contribute to the creation and maintenance of best practice in clinical education, mostly by their input to the external factors.

7. Key elements of a best practice clinical learning environment

To be effective, clinical learning environments must provide learners with an opportunity to experience the reality of professional practice in their chosen profession in a safe and supportive environment. At a minimum this is achieved by providing learners with:

- Access to patients/clients;
- Interactions with clinical staff;
- A context in which the learner can critically evaluate practice and reflect;
- Opportunities for learners to observe skilled role models; and
- Opportunities to take responsibility, work independently (under supervision) and receive feedback.

However, if clinical learning environments are to represent best practice, more than the minimum is required. The following six elements are the essential underpinnings for a quality clinical learning environment. Many of the elements overlap or are interrelated.

Element 1: An organisational culture that values learning

In the context of a health service, an organisational culture that values learning has the following characteristics:

- **Education is valued** – There is an organisational commitment to teaching and learning that ensures all employees, whether directly involved in education or not, view educational duties as beneficial to themselves as well as learners (through a two-way flow of knowledge and self-reflection), rather than being seen as a burdensome obligation. The organisation values lifelong learning and evidence-based practice for all health professional disciplines, and makes an allowance for the productivity impacts of teaching and learning activities. Similarly, there is recognition that in the educational context, mistakes will be made but are valued as learning opportunities for both learners and educators. Learning activities and educational priorities are not "the first thing to go" when budget cuts are required, and innovation is not sacrificed due to funding constraints. Education is valued in the broadest sense, so that all operational activities benefit from organisational learning.
- **Educators are valued** – Educators are appropriately rewarded for their work. The position descriptions of all clinical staff should include statements that define their role, whether active or supportive, in education. The educational components of a person's job are not trivialised (including allocated time for teaching and education coordination, reduced patient load and arranging backup and backfill as required). The skills an educator has are respected and educators are encouraged to continually improve those skills through professional development. Scheduling of educational training is practical and enables staff to attend during their normal working hours. There is recognition of both formal educational qualifications and those acquired through experience or informal training. Educational activities are counted and considered as part of career progression and dedicated teaching positions are established to provide alternate career pathways.
- **Students/learners are valued** – All staff expect the organisation to take learners and their arrival is anticipated and planned for. When learners arrive, they are treated as part of the team, respected for what they bring (new ideas, critical appraisal, future workforce) and given opportunities to learn. Learners are presented to patients in an appropriate way and patients are encouraged by the health service to value education and be accessible for learners.
- **Career structure for educators** – There are defined skill/competency levels for educators (regardless of whether they are formally designated as such) with a clear pathway from one level to the next. Progression through the levels is facilitated and encouraged. Succession planning for educators is a part of organisational human resource planning.
- **Education is included in all aspects of planning** – As is the case for clinical services, education is an essential component of all plans (building, operational, strategic, etc). This means the requirements of the educational activities are taken into consideration during the planning phase, rather than "bolted on" at the implementation phase.
- **Use of facilities and resources are optimised for all educational purposes** – There are dedicated educational facilities that, although available for other purposes, are set up and prioritised primarily for their use in teaching and learning.

The value an organisation places on learning and education will be reflected in its internal policies and procedures and in the way the organisation communicates internally and to the wider community about educational activities.

Element 2: Best practice clinical practice

Best practice clinical practice is the goal of every health service, irrespective of whether the health service is directly involved in clinical education of health professionals, and is a reflection of three main factors:

- **An organisational commitment to quality of care and continuous quality improvement** – This commitment is enshrined in the charter of health services and is monitored through the various accreditation processes that health services participate in, as well as performance measures such as patient/client outcomes. The commitment is exemplified by policies and protocols that encourage and enable high quality care; resourcing that practically supports staff in professional development and implementation of best practice; and the establishment of organisational structures that can assist in developing best practice guidelines and in promoting organisational change.
- **The skill, knowledge and competency of clinical staff** – While the recruitment of highly skilled and appropriately credentialed staff is obviously a key factor, ongoing skill development and regular review of the clinical practice of individual practitioners are essential to maintaining high standards.
- **The adoption of best evidence into practice** – This is both an individual and an organisational responsibility. At a minimum, health services must have protocols for adopting evidence into practice. In some settings (particularly larger health services), this may involve identifying and weighing evidence, then incorporating the best available evidence from a broad range of sources into guidelines that describe current best and achievable practice in a specific area of care, with key sources of evidence being cited. In other settings (including smaller health services with limited resources), guidelines produced elsewhere may be adapted for local use. Since best practice guidelines are intended to promote a consistent and cohesive approach to care, they should be targeted to practitioners using language that is accessible and meaningful. The guidelines should be reviewed regularly and amended as required to take account of new evidence, which may include evidence from published literature, 'grey' literature or local evaluation of clinical experience.

For a health service involved in clinical education, best practice clinical practice also has an educational significance. Not only is the health service aiming to deliver the best possible patient/client care, it needs to model the behaviours, processes and practices to learners so they might understand how best practice is achieved. In fact, the term 'best practice' is something of a misnomer, since it implies finality. One of the most important messages that must be communicated to learners is that achieving best practice is an ongoing process of identifying, implementing and testing the best available evidence.

Element 3: A positive learning environment

Although it is not difficult to understand at an intuitive level, the positive learning environment concept is complex to define, in part because it is a subjective concept. That is, the elements that might make a learning environment positive from a clinical educator's perspective might not be the same elements that make it positive from a learner's perspective. The following list summarises input from learners and educators on what makes a positive learning environment for all stakeholders. Responsibility for some of these issues may be shared between the health service and other stakeholders.

- **A welcoming environment**, where learners receive an appropriate orientation/induction and are included in relevant team-based activities. Learners are made to feel wanted and valued (not a burden) and there are facilities and amenities provided for them.
- **A culture of learning**, as discussed in Element 1.
- **A safe environment** refers to emotional, cultural and professional safety, as well as physical safety. It is a non-judgemental, tolerant environment where learners feel it is safe to participate, ask questions, take chances and make mistakes. A safe environment is one in which learners are measured against realistic expectations in terms of their competence and knowledge. It is also an environment in which struggling learners are identified and assisted.
- **Appropriate learning opportunities** are provided to effectively bring together learner, teacher and patient in the same space, including interprofessional learning opportunities, taking into account where the learner is in their progression from observer to independent practitioner. This also includes

areas such as staff administrative duties and team-based work, which provide challenging, active learning for learners that help them to become practice-ready.

- **Clarity of objectives**, where dialogue with education providers provides clinical educators with information about the expected educational outcomes and the knowledge and proficiency level of each cohort of learners. This also includes awareness of assessment, which is then factored into the clinical education. All health service staff are well-informed about the learner's role during the placement.
- **High quality clinical education staff**, who display appropriate interpersonal attributes, are suitably trained for the task, understand educational principles, are resourced to enable fulfilment of the educator role and are adequately prepared. As far as practicable, clinical education staff should have experience and confidence, be reflective, flexible and good at handling problems. Importantly, they should be committed to the education requirements of their profession (and to their profession in general), have the capacity to work interprofessionally and be a good role model for learners through modelling good clinical practice and evidence-based practice.
- **Well-prepared learners**, who demonstrate professionalism and are willing and able to adapt their learning style to new environments, Well-prepared learners are those who undertake prior reading and make an effort to find out about their new clinical environment (including personnel, team responsibilities and facilities). Preparation continues throughout the placement, with learners expected to spend appropriate amounts of time engaged in reflective learning and practice, research, preparation of portfolios and related activities. Although most responsibility for preparation of learners lies with the education providers and the learners themselves, where health services have some role to play in providing information and encouraging professionalism and other elements of preparedness (such as allowing sufficient time for learners to undertake preparatory activities), they should do so.
- **Appropriate ratios of learners to educators**, to ensure educators are not given too much responsibility to be effective or responsive to individual learners and also to ensure learners have access to experienced clinicians as required. Various awards and accreditation requirements set minimum standards for balancing learner and educator numbers, but best practice will be situation-dependent and may require more than minimum standards.
- **Appropriate ratios of learners to patients/clients**, to ensure that clinical spaces are not over-burdened with multiple groups of learners (not necessarily all from the same discipline) all attempting to work with the same group of patients/clients at the same time.
- **Continuity of learning experiences**, to assist in professional socialisation of learners, allow learners to develop a sense of belonging, and help educators to develop awareness of the learning needs of learners and feel a sense of contribution to their successes. Continuity between learning environments also reduces the amount of time learners need to spend in orientation-type activities, thus increasing the time spent in learning clinical and professional competencies. Familiarity with an environment (or a particular preceptor, educator or facilitator) allows a learner to focus on acquisition of new skills and knowledge. In practical terms, continuity of learning experiences will not always be achievable, for example for disciplines where diversity of practice is necessary to complete training requirements. Even where it is practicable, it will manifest differently depending on the requirements for learning in each profession. In some instances, it may be possible for learners to return to the same health service/hospital for a number of placements. In these cases, continuity of supervisors, preceptors or clinical educators may be achievable; where this is not possible, continuity might be achieved through a clinical education unit that maintains contact with learners wherever they are placed within the health service.
- **Structured learning programmes and assessment**, which recognise and document learning needs and provide timeframes for achieving learning objectives. Where clinical education (particularly for post-registration learners) is not structured or formally assessed, this can diminish the urgency and incentive for both learners and educators and may create a situation where the unstructured learning needs of one group is discounted relative to the structured learning and assessment needs of another group. Structured learning opportunities should be available in all clinical learning environments although the form the structure takes will vary between settings, disciplines and learners. Where formal curricula do not exist (and even where they do), individual learning contracts or learning portfolios can be employed, including explicit statements about expected outcomes and criteria for assessing performance, as well as opportunities for self-assessment and feedback from others.

Element 4: An effective health service-education provider relationship

Clinical education and training is a collaborative arrangement between education providers and health services that draws on the complementary skills, experience, resources and expertise of the two sectors. Although each health service-education provider relationship will be unique, effective relationships – that is, relationships that equitably serve the needs and interests of the partners – have several features in common.

- **Mutual respect and understanding**, whereby the value and importance of both partners is the foundation upon which the relationship is built. In part, this entails respectful acknowledgement by both partners of each other's institutional drivers and limitations that impact on the design and/or delivery of clinical education activities. From the learners' perspective, it is important the health service and the education provider be seen as working together in a mutually respectful partnership; blame shifting and situations that trap learners between two institutions with competing agendas should be avoided.
- **Practical mechanisms**, to assist each partner to optimise their contribution to the training of health professionals. This might include shared administrative resources, robust systems and frameworks for exchanging input and feedback on educational matters, mechanisms to assist small health services to navigate large education provider institutions, or direct exchange of expertise, experience and educational resources (including assessment tools). For example, education providers can support health services by providing educational professional development for health service-based educators. Similarly, health service-based health professionals can assist education providers by teaching pre-placement campus-based clinical skills classes. Protocols to ensure privacy considerations do not become a barrier to the legitimate exchange of information about learners may also be helpful.
- **Open communication at all levels**, to foster and support trust and collaboration. In the first instance, an identified point of contact within each organisation (with back-up, if possible) is essential for establishing and maintaining a good relationship. Regular dialogue between health service and education provider personnel, including face-to-face meetings as often as practicable, is important both in averting problems and in solving them when they arise. Joint committees and/or staff exchange programmes can be useful approaches to enhancing inter-organisational understanding and involvement, particularly for partnerships involving large health services and universities. On the other hand, even the simplest of relationships involving small numbers of students and small health services can benefit from the sharing of electronic educational resources, for example through reciprocal access to institutional intranets.
- **Existence of relationship agreements**, which codify expectations and responsibilities of the partners in the delivery of clinical education. Although legal agreements that cover clinical education activities are common, these agreements tend to be generic and non-specific. While the use of non-specific umbrella agreements can provide some flexibility, there are benefits for both partners in the inclusion of schedules that specify levels of resourcing; responsibilities of both parties in respect of preparation, induction and orientation of students; expectations in relation to supervision of students; responsibilities of both partners in relation to academic support, pastoral care and accommodation for students; expectations with regards to communication and interaction; and other aspects of the partnership. Verbal agreements or agreements based on personal undertakings can easily be misunderstood or misinterpreted, particularly if key individuals depart.

Element 5: Effective communication processes

Effective communication is a key component of most activities within any organisation and, indeed, underpins each element of this framework. From a clinical education perspective, effective communication involves the whole health service, not just those domains or individuals directly involved in educational activities, and is relevant to interactions between:

- Clinical educators and learners, administrators and other health professionals;
- Health service-based educators and education provider-based educators;
- Learners and the range of health professionals, administrators, patients and other learners they encounter.
- Senior managers in health services and senior education provider staff and government representatives.

In the context of clinical education, communication serves three main objectives:

- **Improve teaching and learning**, through exchange of ideas and information (including resources) relating to curriculum content, learning objectives, assessment, and educator and learner needs.
- **Inform actions, behaviours and decision-making**, by clarifying organisational structures and processes, specifying expectations and responsibilities, and identifying relevant individuals or groups.
- **Provide feedback**, through processes that facilitate commendation, comment and criticism equally. To be effective, these processes will also encourage and assist individuals to act on the feedback received and make changes where necessary; as appropriate (and if possible), this should also include reporting outcomes back to the source of the feedback. Good feedback should be specific, timely, constructive, balanced and two-way.

The focus of effective communication processes is on maintaining an active dialogue, rather than addressing failures of communication, and covers both verbal and written modes. Processes need to be carefully constructed to ensure inherently unequal power relationships – particularly those between learners and educators – do not compromise communication.

Communication is a skill that is easily taken for granted and communication in respect of clinical education – particularly between health services and education providers – is often built on long-standing personal relationships. However, effective communication needs to occur irrespective of the individuals involved and therefore health services should ensure their staff are educated about what is meant by good communication and how to achieve it. Furthermore, communication practices need to be reviewed regularly in light of changes in environment and circumstances.

Element 6: Appropriate resources and facilities

The resources and facilities that are required to enhance or facilitate clinical learning will vary between health professions, health services and levels of learners. Therefore, the general principle is that learners – and clinical educators – should have access to the facilities and materials needed to optimise the clinical education experience.

Resources and facilities fall into six broad categories, not all of which are relevant to all health professional disciplines or all clinical education settings:

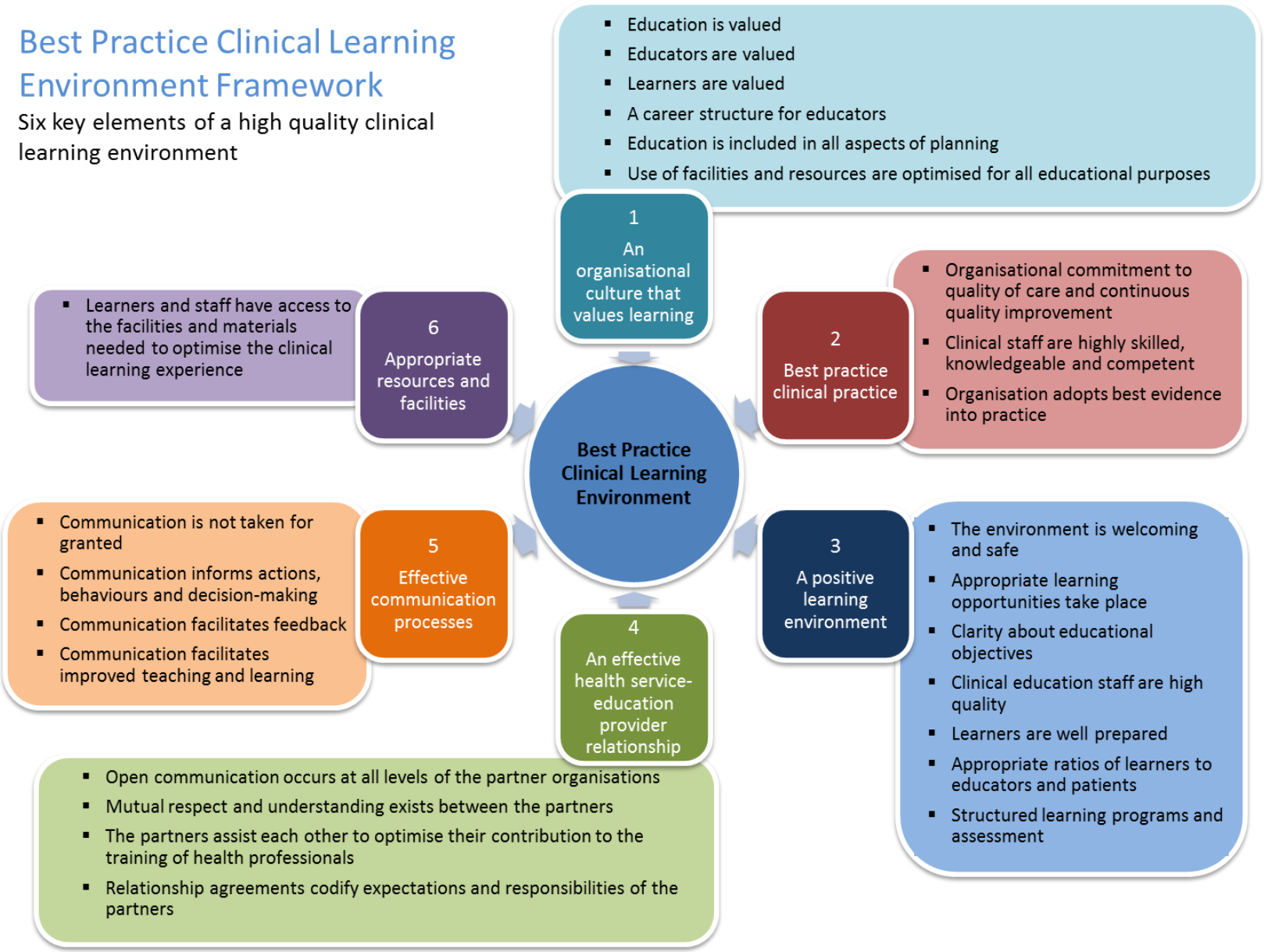
- Capital infrastructure educational facilities – including teaching and learning spaces (lecture theatres, tutorial rooms, clinical skills laboratories, etc) and areas to facilitate reflective practice and for learner/educator privacy during feedback.
- Personnel resources – including designated clinical educators, clinical staff with a primary or secondary role in clinical education; administrative and support staff; pastoral care and counselling staff; academic support, etc.
- Teaching and learning resources – including hard copy and/or electronic versions of materials, library resources (particularly online access, but also textbooks and other monographs), clinical equipment, models and simulation resources (as appropriate).
- IT and communication resources – including computer workstations and internet access, telephones and pagers.
- Amenities – such as social facilities (kitchen and common room), lockers and staff toilets, as well as swipe card access (where practicable).
- Accommodation, work and travel support – in particular, assistance for learners in making short-term arrangements for the duration of a placement away from their home base.

Capital infrastructure is the most problematic category to address, since space is a relatively fixed resource and once buildings are built, it is difficult to incorporate new facilities. Therefore, it is important that educational requirements are taken into account in the planning phase for new buildings and that educational facilities are not always the first to be eliminated when budget constraints bring about a review and modification of the plans.

Importantly, access to facilities and resources should be equitable (i.e. between disciplines and learner levels) and the calculation of resources available to learners should reflect reality. For example, learners may notionally have access to staff computers, but if the computers are constantly in use by staff (or if there are large numbers of learners), then the accessibility of those resources for learners is low in real terms. Therefore, the level of resourcing needed to deliver the required level of access must factor in likely usage by other groups of learners, staff or patients.

Best Practice Clinical Learning Environment Framework

Six key elements of a high quality clinical learning environment



8. Roles and responsibilities

Although this framework applies specifically to health services, all stakeholders in the clinical education system for health professionals have a role to play in creating and maintaining best practice clinical learning environments.

Hospitals/health services

The primary responsibility of health services is to implement the framework to the best of their ability and capacity. At the most basic level, this translates into valuing and prioritising the educational role of the health service as highly as the provision of health care. Developing a culture where education is intrinsically valued requires a strong commitment from senior management.

Health services can further improve overall clinical education outcomes by working with other health services to communicate good ideas and share experiences and learnings from their clinical education practices. One mechanism to achieve this is to ensure key clinical education contacts are identified on each organisation's website and establish education networks and forums that facilitate collaboration and sharing. It is important for health services to use peer influence to encourage each other in the development of best practice in clinical education, as well as working together to influence government policies and priorities.

A significant amount of health service funding comes in the form of support for educational activities, therefore health services also have a role to play in ensuring funds are appropriately and transparently spent.

Health services also have an important role in development and revision of curricula for learners and should make every effort to work in collaboration with education providers to foster development of courses that produce employable practitioners.

Education providers

Higher education providers (including universities and RTOs) have a major responsibility for preparing learners for clinical placements. This includes adequate levels of pre-clinical education, basic clinical skills training and pre-placement briefings. This responsibility extends to supporting the learners throughout their clinical placements, including regular contact with health service-based clinical coordinators, educators and preceptors, and regular contact with learners.

Universities/RTOs also have a major role to play in preparing health services for placements. This includes:

- Recognising their role in funding part of the clinical education process.
- Working with health services to identify the best educational activities and resources to fund and support.
- Working with each health service to match learners to placements.
- Providing up-to-date information to the health services about learning objectives, assessment and curriculum content.
- Assisting health service-based educators to develop their education skills.
- Working with health services to maintain their active learning culture.
- Working with health services to create interprofessional learning opportunities.
- Inviting health service-based educators to contribute to university/RTO educational forums.
- Seeking input from employers regarding the needs and competencies for work-ready graduates in order to appropriately tailor curricula.

When clinical placements are completed, universities/RTOs have a responsibility to debrief with the health services on the conduct of the placement and provide mechanisms for feedback and ongoing quality improvement on their own processes.

Government

As the primary source of funding for public health services and the entities to which health services are accountable, governments have a major role to play in enabling the achievement of best practice clinical education environments.

Health service performance indicators set by governments are a major factor in determining the priority given to educational activities since the impact of teaching and learning activities on patient throughput and other productivity measures is often at odds with the efforts of health services to meet their government-set performance targets.

Therefore, to facilitate best practice in clinical learning environments, governments have a responsibility to:

- Build educational performance targets into the performance measures for health services and fund the health services appropriately to achieve the desired outcomes.
- Resolve policy conflicts that create a disincentive to health services to place a high priority on educational activities.
- Ensure new policies include adequate consideration of any educational impacts.
- Ensure any new health service planning (including building plans) incorporates clinical learning requirements.

Learners

Learners are not passive recipients of education and training and have an important role to play in ensuring their clinical education experiences are of value to themselves and to the organisations that host them. To this end, learners have a responsibility to:

- Understand their role as a learner (including their responsibility for self-directed learning) and be prepared to participate in the two-way flow of information.
- Prepare themselves adequately at the commencement of each new rotation and throughout the placement.
- Demonstrate professional behaviour towards clinical and non-clinical colleagues, patients/clients and other learners.
- Be prepared to adapt their learning styles and respond to a dynamic learning environment.

9. Measuring the implementation of the framework

The development and maintenance of high quality clinical learning environments depends on the recognition – particularly amongst governments and health service managers – of the importance of education in the core business of health services. It also requires a commitment from education providers to consider, more realistically, the needs of the environments in which their learners are trained, and to tailor learning programmes accordingly.

From a health service perspective, developing, strengthening and maintaining a high quality clinical learning environment will be facilitated through monitoring the implementation of the framework. Appropriate and meaningful performance measures will allow health services to identify what is working and what is not working, which will assist in targeting resources to where they are most needed.

Monitoring the implementation of this framework is not intended to place an undue burden on health services through the establishment of onerous reporting systems. Rather, the aim is to establish a number of valid and reliable measures that can be developed and refined over time and that will meet the needs of all stakeholders in the system. In this context, it must be noted there has been little systematic collection and reporting of data relating to clinical education within health services to date. Information that is collected is generally not being used for organisation-wide monitoring of clinical education activities.

The BPCLE Performance Monitoring Framework (PMF) that has been developed as a companion to the BPCLE Framework incorporates 55 indicators across the six elements of the framework. The PMF provides a practical guide for evaluating clinical education activities and incorporates:

- General information about program evaluation;

- Principles that define the assumptions on which the PMF is based, namely:
  - Evaluation is integral to the continual improvement of processes and protocols
  - Evaluation is a dynamic process
  - No single indicator will tell the complete story about the implementation of the BPCLE Framework
  - Monitoring the implementation of the BPCLE Framework should not place an undue burden on health services
  - Individual health services are best placed to determine the indicators for internal monitoring that are most appropriate for their purposes
- Detailed specifications for each indicator, which include the rationale or evidence supporting the use of the indicator as a meaningful measure of quality, as well as specifying the information or data that must be collected for monitoring and reporting against the indicator;
- A weighting system that provides a systematic approach for health services to prioritise the indicators for monitoring; and
- Guidance for health services in relation to data collection, analysis and reporting.

Although the major emphasis of the PMF is on internal monitoring for organisational learning purposes, there may also be value in externally reporting selected indicators to a relevant government department or agency, to allow jurisdiction-wide collection of data relevant to the quality of clinical education and training. For example, in Victoria, the Department has nominated a small number of indicators that may become part of funding and performance criteria, allowing future funding for education and training to be linked to both quantitative and qualitative indicators.

As well as supporting the implementation of the framework, it is anticipated the indicators may fulfil other organisational requirements, including:

- Supplementary information for reviews conducted by accreditation/registration authorities;
- Internal reporting to the Board of the health service (where relevant); and
- KPIs for sharing with education providers as part of formal relationship agreements.

It must be emphasised these indicators only represent a starting place for monitoring implementation of the framework. As empirical evidence on the feasibility and value of these indicators is gathered, the indicators are likely to be further refined.