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Building team for quality learning in clinical placement
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Abbreviations

TMP   Team Management Profile

TMPQ   Team Management Profile Questionnaire

TMS   Team Management Systems

TPP   Team Performance Profile

TPPQ   Team Performance Profile Questionnaire

Acknowledgements

The project team acknowledges the contributions of the clinical team members who participated in this project and thanks them for their enthusiastic engagement. We also thank the senior staff of participating health services for their support of this project.

Thanks are also extended to members of the reference group, the independent evaluator and TMS workshop facilitator, each of whom made a significant contribution to the success of the project.

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Executive summary

Experiential learning is an important component of all health professional education programs and is highly valued by students. In most instances, students are placed with groups of health professionals (the clinical team) who are working together in busy clinical environments to deliver healthcare.

The purpose of this project was to explore the utility of *Team Management Systems* (TMS), a business model for team development as a mechanism for developing clinical team teaching capacity. The utility of TMS in identifying capacity and building clinical teams to support quality improvements in experiential student learning was tested within three diverse health service clinical teams.

The project involved the development of strategies to identify clinical team member roles and responsibilities for facilitating and supporting student learning within a range of healthcare settings and disciplines.

Team members completed a suite of profiling tools and workshops over 9-12 months. Using an action-learning approach, these activities focused on 'who is doing what and why' for student learning, and on the development of quality improvement strategies. Evaluation included pre and post intervention interviews and field observations.

Participants in the project reported developing a greater understanding and awareness, within their respective teams, of the individuality of each team member's work preferences for supporting student learning, and the ways in which this diversity could be used for the benefit of students. Participants also reported better understanding of what it meant to be part of a 'team' in clinical teaching, and of the importance of sharing responsibilities for student learning outcomes among team members.

Specifically, participating clinical team members developed strategies to ensure their students had a better understanding of how their learning was to occur within the clinical team and were able to identify an increased range of options for students to contribute more actively to planning their learning experiences.

In each of the three participating health services, the project was associated with positive changes in practice in relation to managing student clinical placements. Organisational structures and clinical workloads were key factors in determining the extent to which individual teams could change.

Common to all teams was recognition of the importance of cultural change in clinical settings to increase awareness of student learning needs together with each team member's roles and responsibilities in meeting these needs.

The following deliverables were developed through this project:

- a guide for universities and health services wanting to implement TMS as a strategy to support team development and quality improvement around student learning in clinical placements

- a best practice checklist for student clinical placements highlighting key points to consider when planning and coordinating student clinical placements for universities and clinical teams and health services.

The challenges associated with securing high quality workplace learning experiences for health discipline students are common to all Australian university health discipline teaching programs. Through this project, approaches to creating practical and effective change that improve learning and teaching were developed. These changes are transferrable across the full range of Australian learning environments. The importance of securing institutional support and leadership for the successful implementation of change was also reinforced.

Building teams for quality learning in clinical placements

Background and context

In South Australia, three universities offer health discipline programs[1]. Across these universities, programs include medicine, dentistry, nursing, psychology, pharmacy, physiotherapy, occupational therapy, speech pathology, dietetics and nutrition, podiatry and social work. Experiential learning is an important component of all health professional education programs and is highly valued by students. As a consequence, students from each of these three universities are placed within the South Australian health service environment to complete their experiential workplace learning requirements. During these clinical placements, students work alongside experienced health professionals as they go about their day-to-day work activities. In this way, students are encouraged to transform their theoretical knowledge into practical knowledge under skilled guidance (Dornan et al. 2007).

In most instances, students are placed with groups of health professionals (the clinical team) who are working together in busy clinical environments to deliver healthcare. The student joins the clinical team as they undertake day-to-day activities in a process that affords opportunities to refine essential professional skills such as problem solving, critical thinking and teamwork in an authentic context (Hilton & Morris 2001). At the time this project was undertaken within South Australia, over 12,000 clinical placements were organised each year for students enrolled in health profession programs in South Australian universities.

Health professionals, and the clinical teams within which they work, represent a critical interface between the health service and the university. Students who are placed in clinical teams require support and supervision as they work to master high-order technical, professional and interpersonal skills. Clinical team members also require support to assist this process of student learning as they continue to manage their day-to-day work. Health professionals look to the universities for guidance on the key learning outcomes that are expected of students. Although discipline-specific clinical educators and clinical coordinators are employed in many health services to facilitate these processes, the large numbers of students, the variety of clinical teams and the variable and unpredictable nature of day-to-day clinical learning opportunities mean that the primary responsibility for the quality of students' learning rests with individual clinical team members. It is important, therefore, to ensure that specific teaching and learning roles and responsibilities are clearly understood by all members of the clinical team so that healthcare delivery is not compromised and the quality of student learning experiences is enhanced.

The evolution of professional healthcare delivery models has increased the complexity of the relationship between clinical team members, student learning tasks and the role of the university in supporting the clinical learning environment (Reeves et al. 2002). Most clinical teams have multidisciplinary memberships that reflect a range of experience and skills. In addition, specific clinical roles and responsibilities will also shift among clinical team members in response to the demands of different care activities.

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[1]The University of Adelaide, University of South Australia and Flinders University

There is a clear need, therefore, to identify and build team member roles and responsibilities within clinical teaching settings so that all members can contribute effectively to supporting student learning in addition to carrying out their clinical responsibilities (Russell 2006, Robson & Kitchen 2007, Pennington 2003). It is vital, too, to ensure that team members remain comfortable with their roles and responsibilities in supporting student learning, and that they do not become overwhelmed by these duties as they maintain their clinical responsibilities.

Project rationale

The purpose of this project was to explore the utility of Team Management Systems (TMS), a business model for team development as a mechanism for developing clinical team teaching capacity. The utility of TMS in identifying capacity and building clinical teams to support quality improvements in experiential student learning was tested within three diverse health service clinical teams.

Use of TMS within teams offers mechanisms for team members to clarify who is doing what and why within the team, and to develop lines of communication and quality improvement strategies with a view to enhancing learning outcomes for students. A particularly important aspect of the TMS approach is that it takes account of, and values, the individual diversity that exists within teams.

These attributes provided a strong rationale for the use of TMS in this project as a mechanism to support the development of clinical teams for quality student learning. TMS has been field-tested extensively and has demonstrated capacity to achieve positive change in team cultures (www.tms.com.au). Members of the project management team and reference group also had direct experience with the successful application of TMS in student learning and healthcare service contexts.

At the commencement of the project it was our understanding that this project constituted the first application and evaluation of TMS in clinical learning settings. By testing TMS in a clinical team setting, we anticipated that relevant workplace strategies would be identified to develop team member roles and responsibilities in relation to student learning.

The specific outcomes expected from the project included:

- identifying key issues and strategies for promoting quality experiential clinical learning in clinical teams
- evaluating the extent to which student learning can be successfully managed by inter-professional teams rather than within particular discipline contexts
- developing strategies to strengthen connection and communication between universities and healthcare services that maximise student learning opportunities in the workplace
- ways in which universities can better prepare students for experiential workplace learning
- identifying ways in which universities can better prepare students for experiential clinical learning
- producing resources and strategies for effective advocacy in support of quality clinical learning in healthcare settings.

Approach and methodology

An action-learning approach was used to assess the application of TMS within workplace clinical teams. TMS was implemented sequentially across three diverse health service clinical teams with continuous monitoring of interim project outcomes and implementation of modifications to the project plan, as needed, and with subsequent clinical teams to refine the approach. The sequence of testing was selected to allow for increasing levels of complexity in both clinical team composition and functioning.

To assist identification of clinical teams to participate in this project, three elements were defined:

- team composition: the number and range of different disciplines represented within the team

- student programs: the number of different student discipline programs placed within the team

- university relationships: the number of universities placing students within that particular team.

Three contrasting and increasingly complex clinical team profiles were developed by creating combinations of these elements:

- team 1: a single health professional team with students from one health professional program and one university

- team 2: a multidisciplinary health professional team with students from one or two health professional programs and one or two universities

- team 3: a rural multidisciplinary health professional team with students from more than one health professional program and all three South Australian universities.

Three separate health services were approached and one clinical team was sought from each service matching one of the identified profiles. The teams that were selected for participation are discussed in the following three sections.

Team 1: the dental clinic

Team 1 was situated in a community dental service. The clinic provided a range of dental services and operated five days per week where services were provided on an appointment basis. Participating team members included three dentists, one dental therapist, two dental assistants and one practice manager. All students placed with this dental service were enrolled in the dental program at the same university and were completing their final year of study. Two students at a time were placed at the dental service, where they provided dental care to patients under the supervision of one of the dentists. The dental assistant supported the students in the same way as the dental assistant worked with dentists in providing patient care. Student supervision was shared by formal arrangement between the dentists.

Team 2: the aged care facility

Team 2 was situated in a residential aged care facility. Due to the size of the facility and residents' needs, care was provided by a number of clinical teams on a 24-hour basis. Team membership usually included nurses, allied health professionals (such as physiotherapists), aged care workers and other support staff. Due to shift work requirements, the exact membership of these clinical teams varied in composition from day to day. Furthermore, as the residents required ongoing care, not all members of the team were available at the same time to participate in the project. A representative group of staff from across the facility was therefore sought to form a team for the project. Participating team members in this project included the nurse manager, an activities coordinator, a physiotherapist, two registered nurses, two enrolled nurses and two aged care workers.

During the time of the project, nursing students from two different universities were placed with the service. These students were rostered to attend the facility for day or evening work shifts. Allocation of individual students across the facility was determined according to the student's level within their study program, and according to the specifications of the relevant university. The registered nurse in charge of each shift allocated specific tasks to their student. Although the registered nurse had overall responsibility for student supervision, some responsibility was devolved to other members of the clinical team depending on the task being undertaken and the workload for the shift.

Team 3: the rural hospital

The third and final team participating in the project was situated in a rural hospital where patient care was provided on a 24 hour basis. Healthcare was provided by a number of clinical teams comprising on-site staff (nursing, administrative staff and other service personnel), visiting medical specialists and general practitioners who worked in a community-based general practice in addition to the hospital. As with the aged care facility from which team 2 was drawn, it was not possible to recruit an entire clinical team for participation in the project due to the obligation to provide continuous patient healthcare. Therefore, again as was the case with the aged care facility, a representative group of the staff from across the hospital was invited to participate. Participating staff included two doctors, four registered nurses (including a midwife and a student coordinator), an enrolled nurse, and a ward clerk. Each of the participating staff had extensive experience in working with students during clinical placements.

Clinical placements within the health service were provided for medical students from two universities and nursing students from three universities. There was considerable diversity within the student population in the range of education programs represented, students' prior knowledge and experience, and each university's expectations for student learning. This diversity was more marked than in either the dental or the aged care team. Medical students were primarily allocated to the external medical general practice, where they worked alongside these doctors and visited the hospital for specific patient care as required. Nursing students were rostered on to wards and worked shifts in the same manner as nursing students at the aged-care facility. As with team 2, the nursing students assisted with general nursing care under the supervision of the registered nurse in charge of the shift, with tasks and activities allocated to the student according to the student's learning objectives, assessment requirements and overall workload.

The initial plan of the project was to assess the teams in the following sequence: dental service, rural hospital and community aged care facility. However, this initial plan assumed that the aged care service was a more complex service than either the dental service or the rural hospital. Once the project commenced and liaison was underway with staff at these health services, it became clear that the rural health service was far more complex in its operation than the aged care facility and, consequently, the team selected from the rural health service became the third team to participate in the project.

Students

Students from each of the three participating health services were invited to take part as members of the clinical team in each of the three TMS workshops held at the three service locations. Unfortunately no students were able to participate in these activities. Reasons cited by students were most often related to their university study and examination preparation requirements. Student involvement was more successful in other project activities, such as project evaluation interviews.

Project management

The project team (Appendix 1) included the project leader and a multidisciplinary team including representatives from each of the three South Australian universities and the disciplines of medicine, dentistry, psychology, pharmacy, speech pathology and nursing. In addition, an independent evaluator was appointed at project commencement. The independent evaluator participated in all key project activities and provided ongoing formative feedback to the project team, in addition to more formal reporting to the project reference group. The project manager, who was also a member of the project team, worked with the project leader and other team members on the day-to-day aspects of project development and implementation.

The project reference group (Appendix 1) was formed to monitor project implementation and to advise on project development. Reference group membership was determined to optimise stakeholder engagement and to facilitate project execution and dissemination of project outcomes. Project reference group membership was multidisciplinary, with representation from the three South Australian universities, the three participating health services and government. In addition, a clinical educator and a senior academic were nominated as members to ensure input from both health service and university staff with responsibility for student learning and clinical placements. The reference group met at regular intervals over the course of the project and received reports from the project leader and the independent evaluator.

Project planning and alignment activities

To ensure familiarity with TMS administration, processes and outcomes, and to assist in project planning and alignment of project aims, objectives and proposed outcomes, the project team members all completed each of the TMS activities that clinical team members were asked to undertake. Prior to the first implementation cycle of TMS in team 1, the project team members completed the Team Management Profile (see below) and, twelve months later, the Team Performance Profile together with associated workshops. In addition to familiarising project team members with the TMS processes, these activities allowed the project team to review the project implementation plans and evaluation strategies and to agree individual project member roles and responsibilities.

A second workshop and Team Performance Profile allowed a mid-project evaluation of progress. This early engagement of the project team in TMS supported the embedding of a clear vision for the project within the team together with the identification and subsequent ownership of project goals. Individual project team members' roles and responsibilities for achieving project goals were negotiated to optimise project outcomes.

Ethical approval

The research ethics committees of the three participating universities approved the project. Participation was voluntary for all members of clinical teams.

Implementing TMS within clinical teams

Each participating clinical team completed two TMS profile activities. In the context of this project any member of the team who came into contact with students in the clinical environment was considered to be a member of the clinical team. As a starting point, the clinical team completed the Team Management Profile (Figure 1). This initial profiling of individual team member management preferences regarding student learning in the clinical workplace provided an understanding of the range of existing work preferences within the clinical team. The underlying values of this profiling process are developed from recognition that effective teams involve diversity and that individuals have different approaches to work. The information gained from individual members of the team regarding their work preferences in relation to student learning can then be used to harness these differences for the benefit of the student.

The Team Management Profile is a personalised report that gives individuals insights into how they work and their preferred role within a team, based on the Margerison-McCann Team Management Wheel.

The Team Performance Profile provides a view of how well a team is performing in terms of nine critical work functions and serves as a team audit that highlights strengths and areas for development.

The Team Management Profile

Team Management Systems' Team Management Profile Questionnaire (TMPQ) is a 60-item assessment focused on enhancing understanding of an individual's approach to work. Based on the responses to the TMPQ, the *Personal Team Management Profile* provides constructive, work-based information outlining an individual's work preferences, based on the *Team Management Wheel*, and the strengths that an individual brings to a team.
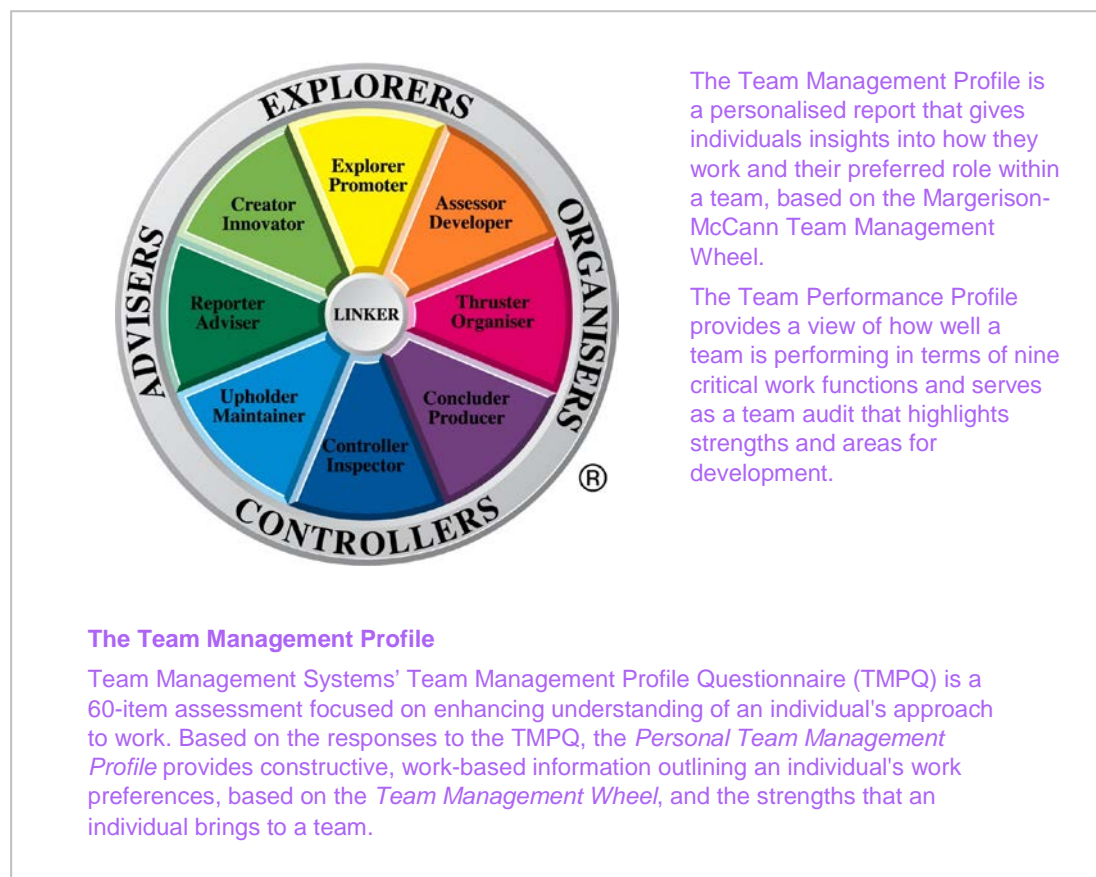
Figure 1: Team Management Profile displayed on a Team Management Wheel (reproduced with permission from Team Management Systems)

Six months after completing the initial Team Management Profile, each member of the clinical team completed the Team Performance Profile, which involved a 360-degree assessment by individual team members of their functioning as a clinical team in support of student learning (Figure 2). In addition, the second activity guided teams in the identification and assessment of improvements that had been made, together with the identification of additional changes to clinical team functioning that might be desired. Each profile activity included individual clinical team member questionnaires and a facilitated workshop conducted by an independent TMS-trained facilitator, as described below.

Initial profiling of individual team member management preferences: the Team Management Profile

To commence the TMS process, clinical team members completed a self-administered questionnaire, the Team Management Profile. This profile consisted of 60 questions and was completed online. In answering each question, team members were asked to describe their work preferences in relation to supporting student learning in their workplace. Individual responses were analysed by the facilitator using TMS processes and an individualised TMS Team Management Profile report was generated. Each report contained general information on TMS in addition to a detailed report and explanation of the individual team member's work preferences.

Once the individual Team Management Profiles were completed and analysed, the members of the clinical team came together for a one-day workshop. The first half-day of the workshop, conducted by an accredited TMS facilitator, addressed the context for the project and provided specific information about the Team Management Profile. Team members each received a confidential printed report describing their personal work preferences. Each individual report also contained tailored information on the team-building skills each member brought to facilitating and supporting learning in the clinical context. The workshop facilitator invited clinical team members to share their individual profiles with the rest of the team. Drawing on these individual profiles, the clinical team then developed an understanding of the distribution of existing preferences for supporting student learning across the team. This synthesis of existing preferences within the team was assisted by mapping each team member's work preferences on the Magerison-McCann Types of Work Wheel (Figure 2).

The second half-day of the first workshop was conducted by the project leader and a team member. Following discussion of the attributes of high energy, successful teams (initiated by the workshop facilitators), priorities for improvement for the team were identified by drawing on the mapped profile of existing work preferences across the entire team. Teams 1 and 2 (the dental and aged care teams) completed this first workshop in a single day. Team 3 (the rural hospital team) completed this workshop over two days, as they were unable to negotiate a whole daytime release for staff. These two half-day workshops were spaced six weeks apart.

Embedding capacity-building processes within clinical teams: the Team Performance Profile

Approximately six months after completing the Team Management Profile, individual participating clinical team members completed the Team Performance Profile. Each clinical team member completed a separate 360-degree feedback questionnaire in which they rated the performance of their team as a whole in relation to supporting student learning.

The Team Performance Profile

For high performance in teams, ongoing assessment is a requirement. The Team Performance Profile Questionnaire (TPPQ) and resulting profile are tools developed to support this process. The TPPQ is a 54-item multi-rater instrument that focuses on assessing a team's performance in nine team performance factors associated with high performing teams.

Figure 2: The Team Performance Profile (reproduced with permission from Team Management Systems

In addition to the clinical team members, the Team Performance Profile was also completed by the team's supervisors and/or managers, and by students who were currently placed with that clinical team. As was the case with the Team Management Profile, the Team Performance Profile (54 questions) was completed online. In answering each question, team members were asked to rate their team's performance in relation to facilitating and supporting student learning in their workplace. The three groups of ratings were used to generate a team profile. This profile was then provided to members at a one-day workshop conducted by the same TMS facilitator who had conducted the Team Management Profile workshop.

As previously, the first part of the workshop involved feedback to team members on the outcomes of the recently completed profile activity, in this case the Team Performance Profile. Team members were able to review the report of their own team's ratings of their performance and compare these to the ratings provided by their students and by their supervisors and/or managers. The clinical team's quality improvement plan and progress on implementation strategies were also reviewed with reference to this assessment of their performance as a team. The extent to which capacity for quality student learning within the clinical team had been enhanced was explored and discussed by the team members themselves. The final component of the second workshop for each clinical team involved a debrief activity where the project leader and project manager provided feedback to the team on the outcomes of the project to date. This report focused particularly on outcomes of the project in relation to that team's participation.

Teams 1 and 2 (the dental and aged care teams) completed this second workshop in a single day. As with the first workshop, team 3 (the rural hospital team) completed this second workshop over two days as they were again unable to negotiate a whole day of time release for staff. These two half-day workshops were once again spaced six weeks apart. Feedback regarding the Team Performance Profile was provided in the first half-day, with the review of the quality improvement strategy development and implementation and final debrief and feedback from the project team, project leader and manager undertaken on the second half-day.

Support for project participants and reinforcing of project outcomes

The project leader and project manager planned to be available to meet with clinical teams between the major workshops to provide support to project participants. These support meetings were scheduled at six to eight-weekly intervals in the initial project planning phase. With team 1, these meetings were an informal discussion of the project team members' perspectives of their participation. As the project progressed, the support meetings became more formalised around reviewing project outcomes and, in particular, quality improvement strategy identification and implementation. By team 3, the support meetings were formally incorporated into the six-weekly facilitated project workshops.

In addition to scheduling additional support meetings for project participants, newsletters were introduced with team 2 and continued with team 3 to summarise key points of workshops for participants. These newsletters summarised content covered within the facilitated workshop and the clinical team's quality improvement planning (Appendix 2).

Project evaluation

A systematic project evaluation strategy was implemented. This evaluation plan was structured around ongoing review of the process of project implementation and the achievement of project outcomes.

Evaluation data were collected in a variety of ways, including face-to-face discussion, participant-completed questionnaires and field notes of observations. Data analysis involved both qualitative and quantitative approaches. To the extent that it was possible, student perceptions of the impact of the project were checked against the perceptions of staff and the observations of the project team. In addition to the reflective evaluation cycles that were embedded in the iterative application of the TMS process, full project evaluation was structured around the following assessments:

- evaluation of the process of using TMS in clinical teams
- evaluation of the impact of the project on team functioning
- evaluation of the impact of the project on student learning
- evaluation by an experienced independent observer.

Evaluation of the process of using TMS in clinical teams

Engagement with the TMS process was assessed in terms of the level of participation in workshop activities by members of participating clinical teams. These activities included the identification and documentation of key roles and responsibilities for student learning and the development of learning quality improvement plans. The project leader, project manager and independent evaluator took field notes during workshops. Participant perceptions of each workshop were also sought. Participating clinical team members completed a TMS evaluation questionnaire immediately after each workshop (Appendix 3)[2].

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[2]This questionnaire included seven Likert scale items and three free response items with higher scores reflecting greater satisfaction with the workshop activity. The questionnaire had been developed and tested by the University of Adelaide Centre for Learning and Professional Development.

Evaluation of the impact of the project on team functioning

Clinical team member individual interviews

Participating clinical team members were each interviewed twice by the project manager during the project. These individual interviews were semi-structured, with questions informed by the goals of the project (Appendix 3). Most interviews were conducted face to face, with a small number conducted by telephone. Each interview was digitally recorded and transcribed anonymously.

Baseline interview. Prior to the clinical team commencing the first profile, the Team Management Profile, baseline data about clinical team member perceptions of current team roles and responsibilities and general team functioning around student learning was sought.

Midpoint interview. Approximately six months later, and just prior to the clinical team completing the Team Performance Profile, the extent to which the team's engagement with TMS processes had been associated with any changes in clinical team functioning was explored.

Final group interview with clinical team members

Approximately six to eight weeks after each clinical team completed the entire TMS process, the independent evaluator conducted a group interview with clinical team members to explore their perceptions, expectations and experiences of the impact of their participation in the TMS project on building capacity for high quality learning within their clinical team[3]. Group interviews were semi-structured, with questions informed by the goals of the project (Appendix 3). Each interview was digitally recorded and transcribed anonymously.

Clinical team work shadowing

The project manager shadowed the clinical team in their workplace for one day prior to the clinical team completing the first profile and just prior to the clinical team completing the second profile six months later. Data were collected in relation to student activities and interactions with staff. Analysis of these field notes was undertaken, including a comparison of pre and post TMS intervention observations.

Evaluation of the impact of the project on student learning

Student interviews

The project manager interviewed students who were placed within each participating clinical team. Student interviews were conducted prior to the clinical team commencing the TMS process (to coincide with clinical team member baseline interviews), and again at the conclusion of the entire TMS process (to coincide with the clinical team member final group interview). As student placements were short, different students participated in each of these interviews. It was not possible to conduct the second interview with students from team 3 within the timeframe of the project as this final phase coincided with the summer university student vacation.

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[3]It was not possible to conduct a group interview with participating clinical team members in team 3 prior to the conclusion of the project. For this team the final independent evaluator interview was conducted with two key team members by telephone.

Each of these interviews explored student learning experiences within the clinical team. The student interviews that were conducted at the conclusion of the entire TMS process also explored whether the clinical team's quality improvement plan had any impact on the quality of their learning experiences. As with clinical team members, interviews were semi-structured, with questions informed by the goals of the project (Appendix 3). Most student interviews were conducted by telephone. Each interview was digitally recorded and transcribed anonymously.

Clinical team member and student questionnaires

It was planned that participating clinical team members and the students who were placed within these clinical teams at the relevant times would complete the Organisational Culture Survey developed by Creedy and Henderson (2006). It had been anticipated that this questionnaire would be completed prior to the commencement of the TMS process and again when the entire TMS process was completed nine months later to allow comparison of pre-intervention and post-intervention scores. Unfortunately, inadequate response rates for meaningful analysis were not achieved.

Student experiences of learning within clinical teams were also to be assessed through qualitative analysis of written student critical incident reports (Robson & Kitchen 2007, Silber et al. 2006). As with the questionnaire above, however, adequate response rates for meaningful analysis were not achieved.

Independent evaluation

An independent evaluator with experience in health service and educational project evaluation was appointed at the commencement of the project. The evaluator contributed to project implementation planning through attendance at all project meetings, and provided valuable advice on evaluation processes as the project unfolded. In addition to attending and providing regular reports to the project team and the project reference group meetings, the evaluator also attended each of the facilitated workshops as an observer. The evaluator provided formal reports to the reference group regarding project progress. The evaluator also conducted exit interviews with key reference group members at the conclusion of the project regarding their perceptions of project success.

Project outcomes

As described earlier, the purpose of this project was to explore the utility of TMS as a mechanism for developing clinical team teaching capacity in order to enhance experiential learning outcomes for students placed in these health care services.

The project team explored the extent to which student learning could be successfully managed by an inter-professional team and identified approaches that would support development by clinical team members of strategies to enhance the quality of student learning. Project participant evaluation of workshop activities demonstrated consistently high levels of satisfaction (Appendix 3).

The project team identified strategies to strengthen communication between universities and healthcare services to optimise student learning opportunities. Ways in which clinical team members could better prepare themselves for the delivery of high quality experiential workplace learning were also identified.

Key project outcomes

1. The development of strategies to identify team member roles and responsibilities for facilitating and supporting student learning

   The project involved the development of strategies to identify team member roles and responsibilities for facilitating and supporting student learning across a range of healthcare settings and disciplines. Participants reported that they developed a greater understanding and awareness, within each of the participating teams, of other team members' work preferences, and of ways in which this diversity could be used for the benefit of students. Participants also reported better understanding of what it meant to be part of a 'team' in clinical teaching, and of the importance of sharing responsibilities for student learning outcomes among team members.

   The identification by clinical team members of changes in team culture and functioning that arose through their participation in the TMS project prompted explicit discussion and planning around how these changes might be sustained into the future beyond the team's engagement with this project.

2. The building of stronger relationships between health services and universities

   As a result of this project, a range of enhanced opportunities for facilitating and supporting student learning were implemented within participating clinical teams. Communication strategies were identified and promoted, both within health services and universities to enhance the understanding of both universities and healthcare services regarding these collaborative opportunities. To enhance uptake these strategies were crafted around the practical challenges facing clinical teachers (see project deliverables below).

3. Changes to culture and practice in clinical teaching environments

   In each of the three participating health services, the project was associated with positive changes in practice in relation to managing student clinical placements. Common to all teams was recognition of the importance of cultural change in clinical settings to increase awareness of student learning needs together with each team member's roles and responsibilities in meeting these needs. Clinical team members developed strategies to ensure their students had a better understanding of how their learning was to occur within the clinical team. Clinical team members also identified an increased range of options for students to contribute more actively to planning their learning experiences. It should be noted that organisational structures and clinical workloads were key factors in determining the extent to which individual teams could change.

4. Project deliverables

The following deliverables were developed through this project:

- a guide for universities and health services wanting to implement TMS as a strategy to support team development and quality improvement around student learning in clinical teams[4]
- a best practice checklist for student clinical placements highlighting key points to consider when planning and coordinating student clinical placements for both universities and clinical teams and health services[5].

Outcomes within each team

Although the TMS process itself was noted to be similar at each site, the decisions taken by staff in relation to quality improvement and student learning as a result of their participation in this project varied widely, being shaped specifically by local needs and conditions. Each group of staff became more aware of, and focused on, their role in helping students to learn. In terms of specific elements of team development, each group started from a unique base and so decisions and changes coming from each team have taken different directions.

Team 1: the dental clinic

The dental clinic was a relatively self-contained health service with the capacity to reorganise the ways in which clinical team members delivered dental services and organised student learning activities. Prior to their participation in the project, many of the members of the clinical team already met regularly as a team to discuss clinical matters. As a result of their participation in this project, this dental team also came to recognise the importance of discussing student learning in addition to their clinical service.

A quality improvement plan around student learning was developed and implemented that resulted in the clinic cancelling bookings for one of their dentists while students were present so that the dentist was free from patient care and able to supervise students fulltime. With this additional supervision, the clinic was able to take more students per rotation. The addition of extra students meant that the same number of patients could be treated each day and the students would receive better levels of supervision and feedback from the dentist.

In addition, there was a reorganisation of the physical layout of the clinic and greater involvement of all members of the clinical team in facilitating and supporting student learning (as observed through the work shadow field observations). At the conclusion of the project, the dental assistants reported feeling better able to provide students with feedback on clinical techniques. The practice manager implemented a system of tailoring patient bookings to take account of student preferences for learning. As one example of this, less experienced students were able to request longer consultation times with patients.

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[4] '*A guide to using Team Management Systems (TMS) for learning and teaching quality improvement in healthcare teams*: a resource developed by the 'Building teams for quality learning in clinical placements" project'

[5] '*Student clinical placements: best practice checklist: key points to consider when planning and coordinating student clinical placements'*: a resource developed by the 'Building teams for quality learning in clinical placements" project'

Team 2: the aged care facility

The aged care facility was a larger and significantly more complex organisation than was the dental clinic. A number of clinical teams operated within the service, with considerable variability in the composition of each team from one work shift to the next. As a result participating clinical team members did not already meet regularly as a group. This significantly diminished the opportunities for team members to communicate with each other around student learning needs.

Participating aged care team members also had less opportunity to reorganise their day-to-day activities in order to improve student learning opportunities than was observed at the dental clinic.

As a result of participating in the project, members of the clinical team decided that a more formal approach to understanding student learning objectives was required and that this was a responsibility of each individual member.

Although the team was unable to make changes to their service-delivery modes in order to better facilitate and support student learning, clinical team members did decide to meet regularly for the specific purpose of discussing student learning. In addition, each member committed to spending more time with students on a one-to-one basis to discuss individual student learning objectives and expectations.

Team 3: the rural hospital

Among the three participating health services, it was within the rural hospital that service pressures appeared to be felt most acutely by staff. A number of hospital staff involved in the project described feeling overwhelmed by the thought of dealing with students on top of their service responsibilities. As was the case with the aged care team, the rural hospital team had few opportunities to reorganise their day-to-day activities in response to student learning needs.

Following participation in the project, members of this team actively committed to regular meetings to plan, advocate and implement quality improvement initiatives around student learning, such as improving their welcoming of new students and ensuring team members knew where and why they would be working with a student.

Overall project impact: perspectives of key participants

In this section, the impact of the project is illustrated using excerpts from the final evaluation interviews conducted by the independent evaluator, and an excerpt from the independent evaluator report.

Independent workshop facilitator: utility of Team Management Systems
TMS is appropriate for clinical teams because of the positive language of the instrument, the level of language. It is user-friendly and easy to understand. The instrument also values differences and enables dialogue and quality of discussion where simpler tools do not go to the same level. In this context, cultural change is supported.

The tools were flexible and the 'high energy teams' [TMS] model works at different levels. The Team Performance Profile opened up the question for each team: what is important for us? The dental team took the viewing of teaching and learning to a different level. In aged care, the staff began to challenge the way things were done. In the rural hospital, there was acknowledgement of an ability to do better, which gave energy to forward planning.

TMS was a good way to start with interdisciplinary teams as it gave a common ground which opened up dialogue. The real beginning was: why do we have a team to support student clinical placements? TMS then encouraged members to look at others' expectations. This led on to the development of ground rules for the team. In this sense, the 'high energy team' models worked well here.

As an enabler of change, the project was recognised by each of the participating teams as a positive influence.

Senior manager team 1: the dental team

As a result of their participation in the project, (this) dental service became a model for managing student learning for the entire state (South Australia). Students were very positive about their experiences of learning in this environment and this clinic, following participation in the project, was seen as a 'productive clinic' where student learning processes were enhanced. Students wanted to go back there. One student has already decided to work at this clinic on the basis of their learning experiences.

We would like to repeat the TMS process in every clinic across the state if the outcome is that we can see more patients in addition to managing our student teaching load. The project gave great value for money. One of the most valuable facets was that outsiders were involved and this enabled cultural change to happen more effectively.

Senior manager team 2: the aged care facility

Following my involvement with the project, a number of gains have occurred. We are identifying groups of staff who can benefit from understanding the educational needs of students better. The more that can be understood of students the better, especially those who might have difficulties settling in from overseas, or speak languages other than English.

The project has sensitised us to ask questions of students. I now meet every student when they arrive on placement. The project has influenced my induction of every student. Now we have a centralised induction on Mondays to prepare students and their documentation of learning plans. The students can now say to the care manager, 'This is what I need to do', and they can negotiate the outcome. The project gave a tremendous return for time/money and the feedback from the manager was very positive.

Team member team 2: the aged care facility

I find that I'm actually making more time for the students. I hadn't had a lot of time before. I'm trying to set aside time to show them (the students), I guess, essentially the paperwork, what's required for admission in aged care and that sort of thing, whereas before, they tended to go off to the registered nurse to do the work.

I think there's probably actually far more subtle stuff happening than we're even consciously think of. We are just doing it differently now.

Team members team 3: the rural hospital team

At the first meeting, I had no idea what to expect. We're just individuals here to do this project. At the third meeting, I realised it was about making a team. As your [our] team developed a capacity as a place for students to learn, yes, but in a small way, people in the team would question what's happening in a different way. We worked differently with students. Students feed this back to the ward.

I can see the need for a team. I never saw that before.

Project participation has given me more compassion for others' viewpoints. It was good to have exposure to understanding teamwork and personalities, as well as understanding ourselves better and analysing our own behaviour.

Has the team developed the capacity of the service as a place for students to learn? Yes, communication has improved. The shortfalls discussed during the project have given clarity on the priorities for action. A team spirit has developed. The specific learning needs of students are being addressed and methods for integrating them into the practical side of things are being looked into.

Independent evaluator
Each service had quite different outcomes from the TMS process in terms of cultural change relating to … learning.

The TMS programs were welcomed, enjoyed and found relevant by all participants. They applied well to clinical care staff due to the accessibility of the language, the focus on different roles in the workplace and the capacity to enable open discussion. The workshops opened a positive space for working as a team taking responsibility for achieving quality student learning outcomes.

The guide and resource pack produced for universities and health services wanting to implement TMS to improve student learning outcomes are clear in design and language, concise and relevant. In short, they are useable!

The success of the TMS programs depended on effective communication between the project team and the sites, how the staff were recruited by their own management, and how they were supported by project staff prior to and following the TMS workshops.

Dissemination of the findings has gone far beyond preparation of materials and conference presentations. Initiatives are already underway in two of the three workplaces to systematize changes for staff and students to achieve improved student experiential workplace learning

Relationship of project to existing knowledge

Embedding and dissemination of project outcomes was a priority throughout the development of this project. To ensure this outcome, there was active involvement of end-users (universities and their clinical education partners in health services) in all aspects and stages of project development and planning.

Factors critical to success of the project

1. Support from participating health services

    From the outset the project received strong endorsement from senior staff within the university and health services sectors. At each stage of project development, local champions stepped forward to facilitate project implementation and team member engagement. This is illustrated in the following feedback from a reference group member:

Linkage between the project and the organisation is critical. Secure and batten down those linkages. (The health service senior management) has always been close to the project. Due to my involvement, both (the health service) and the project team knew this. Secure one person to make the linkage. I saw that as my primary role. This would be advice for future projects regarding selection of members for a reference group. (Project evaluation report)

2. Participant willingness to participate in the project

At the start of the project, participating team members were identified by their respective health services. Following this identification, all further project engagement was determined by the members of the participating teams themselves. Participant engagement and enthusiasm throughout the project continually renewed the energy and focus of the project team and underpinned the overall success of the project.

3. Participant commitment to the provision of high quality learning experiences for students

The commitment of participating clinical team members to the provision of high quality learning experiences for students was a continuing source of inspiration to the project team. The project often acted as an enabler of change that had already been identified as desirable by the clinical team. For example a clinical team member stated:

We were already starting to move on that track last year. This helped us move along, having time to discuss things we wouldn't normally (discuss). Meetings with project team members to establish goals was also important. (Project evaluation report)

4. Selection of appropriate TMS tools and the skilled TMS workshop facilitator

The TMS process and tools proved to be a highly engaging and effective mechanism for the identification and development of capacity within clinical teams. Of critical importance to the support of this process was the skilful and highly effective stewardship of the TMS workshop facilitator.

5. The engagement of the project management team and reference group

The continued active engagement and support of both the project management team and reference group maintained necessary momentum within the project. In addition, the counsel and mentorship of the reference group facilitated effective planning and execution of project activities.

6. The inclusion of an independent evaluator in all stages of the project

The contribution of the independent evaluator as a critical friend in developing an understanding of the factors that were critical to success and factors that posed particular challenges was vital.

7. Implementation of formal processes for dissemination of project outcomes and deliverables

The TMS guide and good practice checklist were both released at a formal

function in May 2010. Representatives from each of the participating health services, the three South Australian universities, SA Health and key health professional bodies attended. In addition, project outcomes have been reported through national and international conference presentations in 2010 including the AMEE conference, Glasgow, the Altogether Better Health Now conference, Sydney, and the ANZAME conference, Townsville.

Dissemination

The key policy and practice audiences relevant to this project included universities that offer health professional training programs, health services that provide clinical placements for health professional students, and government bodies who are responsible for health services and education and training policy development and implementation. High level support for the project was obtained from the three South Australian universities, the health services involved in trialling TMS and with SA Health (South Australian Government). Each of these audiences were consulted and/or involved in all stages of project development and implementation through representation on the project team and reference group membership. In this way, dissemination processes and embedding of outcomes through active engagement with key stakeholders was achieved from the outset of the project.

The challenges associated with securing high quality workplace learning experiences for health discipline students are common to all Australian university health discipline teaching programs. This project has developed approaches to creating practical and effective change in improving learning and teaching practices within health service teams that are transferrable across the full range of clinical learning environments. These approaches to change have built on a considerable body of existing knowledge and practice across university and healthcare sectors.

This project represented the first line-testing of TMS as a strategy to facilitate and support student learning in clinical environments The project team drew on existing knowledge regarding student learning in clinical placements at all stages of project development and implementation. Application of TMS within functional clinical teams permitted refinement of this approach so that it could be more usefully applied to clinical teams in the future. As such, the outcomes of the project are of benefit to all higher education institutions that offer health discipline teaching programs, and all health services that provide clinical workplace learning experiences for students.

As has been noted, the pilot testing of TMS identified strong support and enthusiasm for this approach to clinical team development within the university and health services. This was particularly the case with the reference group members and the dental team. Reference group members in particular were well placed to assist dissemination and contribute to the sustainability of the project outcomes.

Linkages

Throughout the project implementation, the project team explored opportunities to build on outcomes from other work in the area, in particular those funded through the Australian Learning and Teaching Council and the previous Carrick Institute. One such project, 'Leading for effective partnering in clinical contexts', by Creedy and Henderson (2006), was influential in the early stages of planning this project. This project also involved the application of a business model in a clinical learning context, in this case, nursing. The project was nearing completion and Creedy and Henderson agreed to share the tool they had developed in the project to measure learning cultures in clinical workplaces.

Two project team members were also involved in earlier Australian Learning and Teaching Council projects and brought their experiences from this other work to enhance the outcomes of this TMS project. Examples of their reflections included, 'Clarity of goals and information about the purpose of clinical placements is essential to support clinical staff in working with students. Clinical staff are sometimes oversupplied with information from the universities' (Stupans & Ryan 2008), and, 'It is clear that a participative leadership model has been effective as speech pathologists who take students into their workplace have actively sought and taken up training opportunities' (Ferguson et al. 2008).

Sustaining developed capacity

TMS facilitated the development of a shared understanding of learning in clinical teams. This understanding then helped to embed improvement processes in clinical team functioning on a day-to-day basis that supported cultural change within participating clinical teams. Improvements to clinical team member morale and satisfaction arising from project participation were observed in all three teams. In addition, the project outcomes have provided valuable information about the management of student learning within clinical teams and the role of health service organisation in shaping student learning opportunities. This knowledge can now be used to improve student learning experiences and to foster the development of future clinical leaders.

Lessons learnt

Maintaining a flexible approach to the management of complex health service engagement with the project and ongoing communication with all participants was of the utmost importance in this project. In constructing project timelines, the project team believed they had provided adequate lead time for liaison with health services to identify participating clinical teams. The extent to which these time allowances underestimated the actual time required came as a real surprise and underlines the highly complex nature of health service/university interactions. The time required to identify a participating team ranged from four months for the dental team where the CEO was a member of the reference group, to over a year with the rural hospital team where there was no direct involvement of senior hospital staff in the project management structures.

The project team learnt that a champion for the project must be identified and engaged at every level of the organisation and that identification of a clinical team for participation in a project such as this requires detailed discussion and negotiation at every organisational level. It was not possible to create any shortcuts in this process throughout this project. When this understanding is translated into the wider context of ongoing negotiation of clinical placements between universities and health services, it becomes much clearer why communication issues are so frequently identified as problematic. The importance of securing institutional support for the successful implementation of change was constantly reinforced.

For each of the participating teams, organisational structures and clinical workload imperatives were key factors in determining the extent to which each clinical team member could meet with colleagues to discuss learning and teaching responsibilities. This in turn impacted on the team's ability to plan, implement and monitor innovations and quality improvements for student learning opportunities within the clinical team, and to share and support each other in providing these learning experiences and opportunities.

This project was underpinned by an action learning approach. Project implementation in the first team, the dental team, proceeded as anticipated, albeit at a somewhat slower rate than was expected. Through the process of identifying clinical teams within the aged care facility and the country hospital, the project team had to become more flexible in developing a project definition of 'clinical team'. It proved important to take account of the fluid groupings that are involved in in day-to-day healthcare delivery, rather than assuming that a constant and predictable group of clinical team members interacted with the same student on a daily basis.

The second and third teams were unable to release all their staff to attend whole-day workshops. To cope with this requirement, the participants in clinical teams 2 and 3 were drawn from a range of different health disciplines from different parts of the health service. It is not considered that this compromised the project outcomes. Indeed, it permitted different insights into ways in which student learning could be improved. It also meant that quality improvement planning occurred at a more facility-wide level rather than being limited to a small group of co-workers. It was clear, however, that full-day workshops were preferable to the half-days requested by team three.

As was initially planned, members of the reference group and the project team played key roles in facilitating liaison with individual health services and in securing clinical team participation. In addition, reference group members actively promoted the project and, in particular, the project outcomes within their respective organisations.

One particularly positive outcome of the broadly based consultation that was required in order to implement the project in the selected clinical teams was the engagement by the project team with a number of health professional and health service staff. In these discussions, the key aims of the project were promoted and, following project conclusion, outcomes were disseminated directly to key staff and individuals. There was complexity in ensuring that all required communication channels were appropriate, and that appropriate staff were consulted at every stage of the decision-making. It was also of paramount importance that health service users were not disadvantaged by any phase of the project.

The independent evaluator provided feedback to the project team with suggestions for improvements that were highly useful. The feedback was provided in a sensitive and supportive way and in this sense the independent evaluator also provided significant support and debriefing opportunities for the project leader and manager in particular. The independent evaluator was able to identify activities that worked well within workshops as well those that did not work as well. Suggestions were then offered for a change in order that the next time the workshop was delivered, it would work more effectively.

The evaluation questionnaire after each workshop provided uniformly positive feedback and indicated that participants were highly engaged with the process and very positive toward this engagement. Project team discussions with the reference group also demonstrated the value of bringing together different discipline perspectives and insights in reviewing project process.

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Appendix 1: Project team and reference group terms of reference

Project management committee

Role/Terms of reference	
Nature:	The project management committee will be responsible for all aspects of project implementation, management and evaluation
Terms of Reference:	The project management committee will;

- facilitate liaison with participating clinical teams
- facilitate project participant recruitment,
- oversee information and consenting procedures
- contribute to project implementation and plan ongoing project management
- oversee project evaluation planning and implementation
- conduct ongoing review of project outcomes
- receive monthly progress reports from the Project Manager including financial reporting
- provide feedback to participating clinical teams on the outcomes of their participation in the TMS process
- report to the Project Reference Group through the Project Leader
- contribute to the preparation of interim and final reports as required by the Carrick Institute

Frequency of meetings:	Monthly throughout the project

Membership

Associate Professor Maree O'Keefe (Convenor)
Associate Professor Ieva Stupans
Ms Linda Saunders
Dr Sue McAllister (Project Manager 2008)
Ms Teresa Burgess (Project Manager 2009/10)
Mr James Burgess
Associate Professor Amanda LeCouteur
Ms Jennifer Miller

Project reference group

Role/Terms of reference	
Nature:	The project reference group will monitor project implementation and advise on project development to optimise stakeholder engagement, facilitate project outcomes and dissemination.
Terms of Reference:	The project reference group will:

The project reference group will:

- identify strategies to support liaison with participating clinical teams

- monitor processes for project participant recruitment, information and consenting procedures

- advise on project implementation

- advise on ongoing project management

- monitor project evaluation

- monitor project outcomes

- receive regular reports from the Project Leader

- receive regular reports from the Independent Project Evaluator

- monitor feedback to participating clinical teams on the outcomes of their participation in the TMS process

- review interim and final reports to the Carrick Institute

Frequency of meetings:	Each three months throughout the project

Membership	

Professor Johann de Vries (Convenor)
Associate Professor Maree O'Keefe (Project Leader)
Associate Professor Ieva Stupans
Ms Linda Saunders
Dr Sue McAllister (Project Manager 2008)
Ms Teresa Burgess (Project Manager 2009/10)
Associate Professor Dee Whitford
Mr Jan Van Emden
Dr David Clark
Ms Stacie Attrill
Ms Catherine Turnbull

Appendix 2: Sample workshop running sheet and newsletters

Building teams for quality learning in clinical placements

Workshop 2

9.30	Recap first workshop Including discussion in pairs Questions
10.00	Draw an ideal team in pairs Guide facilitator in drawing the relationship between the clinical team, students and universities
10.15	Go to work wheel Discuss project team wheel in implications for working together Draw blank work wheel and populate for teaching activities
10.30	Break Team to put dots on their work wheel if they remember their profiles Look at current distribution of team preferences What are the implications
11.00	Revisit initial team goals Goal box activity (Individual exercise to nominate goals and place written notes in a box) Quality improvement planning based on ideal box results (list results and dot voting)
11.45	Top 3 goals and action plan
12.00	Thanks, close, what is next and lunch

Aged Care Service
Building Leadership for Quality Learning

In the last newsletter we reported what you had said about ideas the profile sparked for you, what things you would like to know more about and what you already know about good teaching. You described a vision of how you would like the learning environment and staff to be for students when they come to the Aged Care Service.

During the workshop you also thought about challenges and opportunities to provide quality student learning experiences. You identified some ways you could address these. This newsletter feeds back those discussions and poses some questions for you to think about.

PROJECT NEWSLETTER MAY 2009

During the March workshop your team shared your passion for student learning in aged care and your aim to provide high quality learning experiences for students.

We are looking forward to meeting with you in June to discuss these questions and decide where you would like to start with some of the ideas that you came up with during the workshop.

Challenges and opportunities for student learning at the Aged Care Service

What opportunities does our teaching team have?
- Use the Team Management Profile to adjust our teaching styles
- To influence community attitudes to Aged Care
- Educate other staff on what we do.
- Give students real experience of the residents' needs
- To promote Helping Hand.
- Create more interaction between all parties involved in the training of students
- Use the education program to recruit staff for Helping Hand
- Build the students' empathy for residents

Things to keep in mind when planning to improve the learning experience?
- Maintaining staff morale
- Improving agency staffs' understanding of Helping Hand's way of doing things.
- Making sure that residents understand that students may take longer than trained staff
- That training time doesn't negatively affect how much work gets done
- Managing some residents' lack of cultural awareness
- Matching students with staff rosters and leave

Our team has a lot to offer as a teaching team;
- We have a strong ethos and passion for our work
- We have the right skills, knowledge and experience.
- We have all disciplines in one site.
- We have good resources for learning.
- We have good partners.
- We provide good feedback.
- We communicate well with each other and people who visit us
- We know each other and how to deal with others.
- We can match the right staff with students.
- We are volunteers, teachers and coaches.

What would help our teaching team?
- More facilities for training.
- More time.
- More information about the students , their experience and learning profiles
- Lower case-loads
- Strong guidelines to allow clear limits to be set.
- Students and the community to have a positive perception of Aged Care.

THE UNIVERSITY OF ADELAIDE
AUSTRALIA

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AUSTRALIAN LEARNING &TEACHING COUNCIL

Ideas for Action

Here are some of the suggestions you came up with to act on your ideas

1. Improve communication with the Universities and TAFE
   - Visit universities/TAFE and give lectures or information to students
   - Regular meetings with Aged Care Service staff, University staff and students.
   - More contact: written, phone, text, email and face to face.
   - More feedback from our learning partners on the student experience.

2. Develop an IT friendly timetable for placements at the Aged Care Service that shows staff's rosters and leave and when students will be placed.

3. Better understand learning needs
   - Tell students about and let them choose from the options for learning at the Aged Care Service
   - Have a student mentor scheme
   - More information and interaction with University/TAFE facilitators and the Aged Care Service staff about the students' scope of practice and required learning activities

4. Promote aged care as a placement
   - Survey students about what information would be useful
   - Ask the Development Unit if they could assist in producing an information pack
   - Provide an information pack for students about
     * Competencies they can develop here
     * Case studies of student learning experiences
     * Tasks and activities students can be involved in
     * Biographies of the teaching team
     * The Aged Care Service's philosophy of care
     * The Aged Care Service's history and mission
     * Career opportunities at the Aged Care Service

Priority areas for the teaching team

There were 4 main areas for action that you thought would help your team achieve its vision of providing quality learning experiences in aged care:

1. Improve communication with the Universities and TAFE
2. Timetabling to make sure students are placed when there are enough regular staff for students to get the most out of it.
3. Better understand learning needs
4. Promote aged care as a placement

Taking Action

⇒ Are there any other areas for action you can think of?
⇒ Are some more important than others?
⇒ Which idea interests you the most?
⇒ Look at your TPP Profile. What ideas for action would you enjoy doing?

Increasingly within Clinical Team settings, students are interacting with professionals from different disciplines to their own.

Just as clinical roles and responsibilities shift around among team members, clinical team roles and responsibilities for student learning are frequently transferred from one professional to another, depending on the context

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Appendix 3: Evaluation interview topic guides and workshop evaluation questionnaires

Pre-TMP evaluation: Staff individual interviews topic guide

How do you find having students?
How does your team manage student learning at your service?   *Prompts*   • *Who does what?*   • *Is it a particular person's role?*
What do you think students learn at your service?   *Prompts*   • *What do you think that involves (knowledge/skills/attitudes)?*
How do they learn those things?   *Prompts*   • *What strategies or resources do you use to help them learn this?*
What works well when you have students placed with you?   *Prompts*   • *What helps the team function well when students are around?*   • *What helps the students get the most out of their placement?*
What do you think could be done better when students are placed at your service?   *Prompts*   • *What would help the team function well when students are around?*   • *What would help the students get the most out of their placement?*

Pre-TMP evaluation: Student group interview topic guide

Activity
What's it like being a student in this clinical team?
How do members of the clinical team support your learning?

This project is interested in how clinical teams work together to help students learning.
 	
    What do you think should happen?
 	
    What would make learning in this clinical service better?

We are going to give the team feedback about who likes to do what in relation to supporting students' learning in this service, and develop a plan on what needs doing and who should be doing it.   Do you think that would make a difference for your clinical learning?
Anything else you think should be considered to improve the learning experience here for students?

Pre-Team Performance Profile: Staff midpoint individual interview topic guide

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How do you think the project is coming along?

What has it been like for you participating in this project?

Prompts

- *Is there anything in particular that you learnt or found helpful?*
- *What were you expecting - has the program met these expectations?*
- *Have you thought more about your leadership role in student learning?*

What do you think it's been like for the team to participate in this project?

Prompts

- *Has it been positive/negative?*
- *what benefits have there been for the team? What are these ?*
- *Has there been more 'sharing' of student teaching tasks around the team?*

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In the past, to what extent had you considered yourself to be part of a team supporting student learning?

If yes – Who did you feel part of a team with

If no - Has that changed for you, for others?

Can you give an example?

Have you noticed any changes in the way the student learning is managed since the project started?

Prompts

- *Do you think anything has changed for students?*
- *Any changes in: Who does what? Who is responsible? How things work for students?*
- *Can you give an example*

Have you changed anything you do to support students' learning?

Prompts

- *Anything changed about the way you think about student learning?*

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What have you noticed about what the students are learning, or how they are learning in the last few months? (or this year compared with last year)

How do you know when students' learning is going well?

So, your criteria for student learning could be…(*paraphrase answers from previous Q*)… *Do you want to add anything else?*

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At the first workshop the team identified several goals. How useful was that, and have any changes been made as a result?

Are there other things that should be done to help students to learn?

Are there other things the University could do to prepare the students to make the most of their learning opportunities here?

Are there skills that you would like to develop further so you are better equipped to teach students in your workplace

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What parts of the project so far have been most useful for you or the team?   *Prompts*   • *TMP profiles, first workshop, team and individual goals, follow up meetings One or Two*   How useful was it having your TMP profile identified and explained?   Was it useful to identify team goals?   *Prompts*   • *Any in particular?*
What parts of the project so far have been the least useful for you or the team?   *Prompts*   • *Anything you think we should change?*   • *Would you do it again?*
What would you like covered in the last workshop?
The project has required quite a time commitment from you. If another team asked you if it was worth this amount of time, what would you say or recommend to them?
Any other comments?

TMP/TPP workshop evaluation questionnaire

Thank you for your participation in this workshop. It would be most helpful if you could provide us with feedback. Your responses are confidential, and cannot be personally identified. Please do not provide any other personal information or write your name on this questionnaire.

Please circle the appropriate number for each question.

	Strongly Agree			Undecided		Strongly Disagree	
The workshop achieved its purpose.	7	6	5	4	3	2	1
The content of the workshop was interesting.	7	6	5	4	3	2	1
The workshop met my expectations.	7	6	5	4	3	2	1
The workshop content was relevant.	7	6	5	4	3	2	1
The workshop was at the right level for me.	7	6	5	4	3	2	1
The workshop catered for people's different learning styles.	7	6	5	4	3	2	1
The presenters were easy to follow.	7	6	5	4	3	2	1
The presenters were responsive to questions.	7	6	5	4	3	2	1
The workshop allowed me to participate.	7	6	5	4	3	2	1
The right amount of time was available.	7	6	5	4	3	2	1
The workshop was well organised.	7	6	5	4	3	2	1
The materials provided were of high quality.	7	6	5	4	3	2	1
The workshop provided practical ways for what we have learned to be used at work.	7	6	5	4	3	2	1
I intend to share information from this workshop with other colleagues	7	6	5	4	3	2	1

Please respond to the following questions:

The most useful part of the workshop was:

The least useful part of the workshop was:

Additional comments:

Summary of the first (TMP) and final (TPP) workshop evaluations from the three participating organisations

Likert Scale:

Strongly Agree			Undecided / Disagree		Strongly Agree	
7	6	5	4	3	2	1

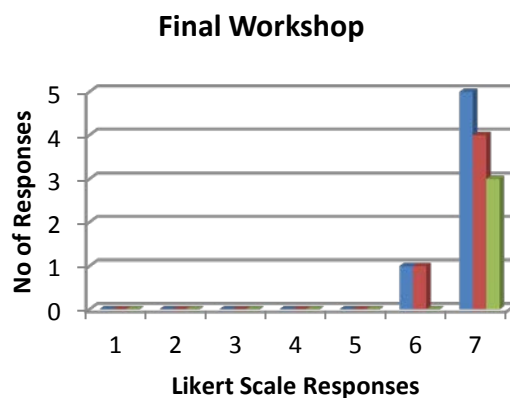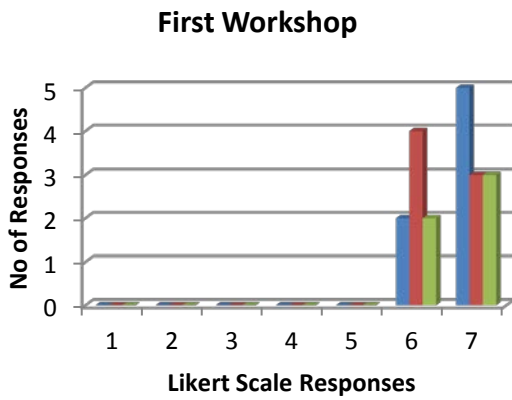| ■ Dental Team	■ Rural Hospital	■ Aged Care Facility

1. The workshop achieved its purpose.

First Workshop

Final Workshop

2. The content of the workshop was interesting.

First Workshop

Final Workshop

3. The workshop met my expectations.

First Workshop

Final Workshop

4. The workshop content was relevant.

First Workshop

Final Workshop

5. The workshop was at the right level for me.

First Workshop

Final Workshop

6. The workshop catered for people's different learning styles.

First Workshop

Final Workshop

7. The presenters were easy to follow.

First Workshop

Final Workshop

8. The presenters were responsive to questions.

First Workshop

Final Workshop

9. The workshop allowed me to participate.

First Workshop

Final Workshop

10. The right amount of time was available.

First Workshop

Final Workshop

11. The workshop was well organised.

First Workshop

Final Workshop

12. The materials provided were of high quality.

First Workshop

Final Workshop

13. The workshop provided practical ways for what we have learned to be used at work.

First Workshop

Final Workshop

14. I intend to share information from this workshop with other colleagues*

First Workshop

Final Workshop