Professor Lynn Robinson is the Director of Research and Development at the Centre for Innovation in Professional Learning (CIPL), The University of Queensland, where her interests are in large-scale professional workforce capacity development, particularly using online networks. Before joining CIPL in 2010, she had a long career in the health care sector encompassing general practice, hospital administration, health system reform and health systems research. She has had a lifelong interest in education and has taught many thousands of health professionals on topics related to clinical leadership, teamwork, innovation and quality and safety.

Multimedia resource
In addition to the lecture transcript below, this lecture is available as a multimedia presentation (audio over PowerPoint slides).
Delegated practice: professional development

<table>
<thead>
<tr>
<th>Slide number</th>
<th>Slide</th>
<th>Transcript</th>
<th>Enter your notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><img src="image1.png" alt="Image" /></td>
<td>Title slide</td>
<td></td>
</tr>
</tbody>
</table>

Delegated practice: professional development

Professor Lynn Robinson
In this session we’re going to explore the professional development responsibilities inherent in clinical supervisory relationships.

I recommend that you consider using formal learning plans as a very useful teamwork tool.

Although it’s not possible to cover any but the most basic and useful concepts and techniques for clinical teaching, we will look at a few of these too.
<table>
<thead>
<tr>
<th>Slide number</th>
<th>Slide</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Consensus definition: 2000 UK</td>
<td>Perhaps we could attempt to get a consensus definition of clinical supervision, before we move on. After exploring a wide variety of literature, in the UK in 2000, these authors had some difficulty in actually preparing their report until they defined clinical supervision for themselves. So they came up with this consensus definition from the literature, which is that clinical supervision is the provision of guidance and feedback, and it’s on a range of matters - personal, professional and educational development - and it occurs in the context of a trainee's experience of providing safe and appropriate patient care. In our context, an assistant’s experience. I’ve broken it down into those three separate lines, because I actually think those three lines deal with different aspects of clinical supervision.</td>
</tr>
</tbody>
</table>

[1]
Well that was a consensus statement, but how much consensus is there really about the definition of clinical supervision?

Well, there’s broad consensus on a couple of things. One is that it is, at least in part, about promoting patient safety, at the same time as promoting professional development. So it’s a balancing act between the safety of the patient in a clinical setting, and the needs of the learner to develop.

Most people agree that there are three primary functions of supervision: an educational one, a supportive or mentoring one, and that there are some managerial or administrative functions of supervision, which in this context, I guess, would include elements of quality systems that ensure patient safety.

But there is a significant divergence, and it appears to be on this issue that some authors place a great emphasis on professional development, and some authors place a great emphasis on patient safety.

In your discussions I think some of this...
might come out, that depending on context, the emphasis might be different on professional development or patient safety; the balancing act might balance slightly to one side or slightly to the other, depending on the circumstances of the supervision.

For the next little while, we're going to focus on the educational or professional development role of the clinical supervisor.

I am a great believer in tools, so I offer you this tool as a way of structuring that part of the supervisory relationship between the clinical supervisor and the assistant.

It's pretty clear I think from the layout that it is just a simple mutual commitment to identifying performance gaps and learning opportunities and addressing them together. Reviewing this plan could be a regular agenda item on your supervision meeting or session, or perhaps done as part of a team quality activities or, least usefully, I think, as part of an annual performance review.
<table>
<thead>
<tr>
<th>Slide number</th>
<th>Slide</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I say “least usefully” because I think that annually is far too infrequently to think about professional development, and that placing it only on an annual review also makes it more performance-based rather than about the quality of care possible in a teamwork setting. Note that both these goals, if achieved, are going to directly effect the team performance and care delivery (the goals I refer to being the ones in the example plan that you’re looking at).</td>
</tr>
</tbody>
</table>

© State of Queensland (Queensland Health), 2013. No part of this document may be reproduced without the express permission of Queensland Health.
So let's have a brief look at the types of teaching methods you might employ as a clinical supervisor.

One method a supervisor might use is to have the trainee or assistant observing, to model professional behaviour. You might use case presentations, where the trainee engages with the patient and then presents that back. And that might trigger some directed readings potentially from the supervisor.

The supervisor might use direct questioning. This is the technique where you would be quizzing the thought processes of the trainee to stimulate reflection.

- ‘Why did you do that?’
- ‘What were you thinking when you made that decision?’
- ‘Did you consider using any alternatives?’

Another technique that looks similar to this is where, as a trainee is in the act of going through a process or a procedure,
we might be saying to them:

“I want you to think aloud, tell me what you’re thinking as you’re doing this, verbalise your process as you go.”

Related to this coaching, where the trainee is undertaking a procedure or a clinical activity, and as they are doing that, the supervisor is injecting verbal clues as necessary to keep them on the right track and assist them along.

A key part of teaching methods is clearly giving feedback, so that deficiencies can be corrected and trainees can track onto a professional model of care. I don’t propose to go into these in any detail, but they’re all basically techniques that are used when working alongside someone in a clinical setting.

I would encourage you to undertake some further professional development on teaching in clinical settings if you have not done so already. It is much more interesting than you might imagine and very helpful to not only your students and assistants, but it also makes you a better reflective practitioner and learner in your own right.
It’s helpful to be aware that the dynamics of the supervisory relationship change over time. And as the trainee’s proficiency grows as a result of the professional development pathway, then we expect to see the trainee incorporating what they know into knowing how to apply that, and being able to demonstrate that, and ultimately then being able to perform as a clinician.

I’ve just re-drawn, I guess, the stages of Miller’s Pyramid, which I’m sure you’re familiar with, to put that on a line of a continuum of experience over time.
One of the things that this continuum does is put challenges on our teaching style, as the learner goes through that continuum. This model, situational leadership, has been used for a long time in other sectors and has recently been applied in the health care sector, particularly by people at the University of Sydney, in teaching research skills in primary health care, and I'm sure probably in other circumstances. Let me give you this model briefly.

What we're looking at here is the student phases of learning, as they move through the professional development pathway. At the beginning, the style of the learner is described in this model as an enthusiastic beginner. Sometimes this can be explained as someone who is unconsciously incompetent. The motivation levels are high, energy levels are high, and the beginning student wants to apply what they've learnt in books to a real life situation.

Now, I have to tell you a story of my own unconscious incompetence when I was a reasonably bright, wildly enthusiastic young medical student, throwing myself
into my first internal medicine rotation. We had an excellent clinical supervisor in our medical registrar for this rotation, and I was completely convinced that I had discovered in an elderly patient that I was assigned to, an extremely rare condition of the pituitary caused by gross blood loss during childbirth. The fact that this woman was 81 and hadn’t shown the symptoms of this condition until the point where she was admitted recently to hospital didn’t stop me from betting a case of beer (that was in order to be allowed to request the necessary blood tests) on the fact that she had this obscure syndrome. Oh the confidence of naivety of the inexperienced and a little book knowledge!

The loss of the bet, which was no small price on my student allowance, was the least of it. I discovered that in fact what you learn in books isn’t all you need for diagnostic acumen. I had quickly became consciously incompetent. How was I ever going to be a real doctor like the medical registrar clearly was? I had arrived at the second phase – the disenchanted learner. And this is the point where motivation tends to drop, and the students often feel are less
<table>
<thead>
<tr>
<th>Slide number</th>
<th>Slide</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>engaged in learning than one would hope and it takes a real effort to pull them through to the point where they pick up their energy levels again, and move to the next stage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>And the role of the supervisor of course is to draw this process along. So stage three would be described as a D3 learner, who is capable but cautious, and using another model of learning theory, we’d call them consciously competent. So they’re putting a lot of effort into performing reasonably well, and beginning to get their motivation back, but the level of effort is such that they need a fair bit of support. And what we’re hoping to actually achieve is that we’ll be able to develop these people to be self-reliant achievers, which is the fourth level.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Now on the other side, what we really need as clinical supervisors is to adapt our leadership style, so that we’re providing what is required for the learner at the different stages of development.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In the first level, the relationship is largely about task direction, giving lots of instruction and specific instruction about</td>
</tr>
</tbody>
</table>

© State of Queensland (Queensland Health), 2013.
No part of this document may be reproduced without the express permission of Queensland Health.
<table>
<thead>
<tr>
<th>Slide number</th>
<th>Transcript</th>
<th>Enter your notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>how to undertake work, what you expect of the outcomes of that work, and even the specific process of the task.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>At the next level it's more about coaching, supporting, building on the relationship with the clinical supervisor, and trying to maintain the motivation and interest of the students as they go through that next stage of learning. By the time we get to the capable but cautious performer, the balance has moved much more towards it being mainly about the relationship, the supportiveness of the relationship, and providing motivation and a reduced level of task direction being available.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Until at the end, the trainee is quite capable of having delegated authority and accountability as a team member in the activities in which they have been developing the competency.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The point of this slide is, in summary, to supervise well, first assess where the learner is up to, then apply the appropriate style of leadership to support their development to the next stage.</td>
<td></td>
</tr>
</tbody>
</table>
The last stage of course: trustable, self-reliant achiever. We need to pause for a second and talk about ‘trustable’.

I found this interesting quote from the literature some while ago, and I think it certainly speaks to me about the real outcome of training in a clinical environment. We’re moving more and more towards looking at competency rather than just knowledge or skills, and I think this quite draws out some of the reasons why we’re interested in this.

That adequate performance of a task includes the ability, or adequate performance as a practitioner, rather, includes the ability and the inclination to apply competence in a way that optimises the outcome of those activities. Ultimately this is about patient outcomes. So this reaches further than being able to observe someone’s ability in a synthetic environment, or even in a limited way in a clinical environment.

The real outcome of training that we’re looking for is ultimately about the quality of patient care. As expert clinicians, I’m sure you’ve all had the experience where you feel comfortable trusting a
student or a trainee or a colleague in a team environment, and you know that that person is trustable; is a safe pair of hands.

I think that the perhaps the illusive nature of this lies in the way the relationship works between that person and their colleagues. Beyond a known competence is the way that person handles themselves when they are unsure or circumstances change, or when they are asked to do something they are not comfortable with. These are things which are the fruit of mutual respect, transparency and practiced authentic teamwork. Both clinical supervisors and assistants can contribute to this level of performance through building effective relationships.
So, we have touched on the professional development responsibilities of the supervisory relationship. At one level this can be structured through learning plans and facilitated by skilful clinical teaching. But, ultimately, the quality of care depends on not only the achievement and execution of clinical competencies on the part of the assistant or trainee, but also on the success of the relationship between the supervisor and assistant. It all comes back as it so often does to the importance of teamwork.
References

6. Cate OT. Trust, competence and the supervisor’s role in postgraduate training. BMJ 2006;333:748-751.
Learning Goals

Have you met these Learning Goals?

- Understand the role and application of situational leadership to delegation practices and clinical supervision.
- Understand a conceptual model of the relationship between clinical supervision and clinical skill development.
Professional development and improved delegated practice

Group learning

Table of contents
1.0 Miller’s Pyramid
2.0 Situational leadership and skills development

Learning Goals

- Identify models of delegation, clinical supervision and skill development

Reflection
If your team is working progressively through the materials in this workshop over a period of weeks, take a moment to quickly refresh your memory of what you have previously covered in this workshop before continuing on with this new topic.
1.0 Miller’s Pyramid

This slide is taken from Professor Lynn Robinson’s presentation ‘Delegated practice: professional development’.

**Group discussion questions**

How will your understanding of Miller’s Pyramid assist you to improve your teamwork or performance?
2.0 Situational leadership

This slide is taken from Professor Lynn Robinson’s presentation ‘Delegated practice: professional development’.

Group discussion questions

Consider specific situations where you are engaged in delegated practice.

How will your understanding of Situational Leadership assist you to improve your teamwork or performance?

Be as specific as you can, including documenting proposed actions or changes in the following space provided.
Learning Goals
Have you met these Learning Goals?

- Identify models of delegation, clinical supervision and skill development

Authority

This training program has been developed by The University of Queensland’s Centre for Innovation in Professional Learning for use by the Department of Health and Hospital and Health Services established under the Hospital and Health Boards Act 2011 (Qld).