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GREATER NORTHERN AUSTRALIA
REGIONAL TRAINING NETWORK

A Guide to Creating a Culture of Quality Supervision

Work-Based Peer Review of Clinical Supervision Practice

November 2014

AN EDUCATIONAL RESOURCE

The Greater Northern Australia Regional Training Network (GNARTN) is a cross-jurisdictional collaboration between the Western Australia, Queensland and Northern Territory Departments of Health, made possible by funding provided by Australian Government Health Department.

This report was commissioned by the GNARTN Council. The findings, outcomes and recommendations of this report, do not constitute agreement or endorsement from the individual partners or governments who are party to the GNARTN Council and/or its processes.

This publication underwent a peer review process which involved impartial and independent assessment of the publication in its entirety before publication, conducted by independent, qualified experts.

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Suggested citation:

Campbell, N., & Wozniak, H. (2014) Work-based peer review of clinical supervision practice: A guide to creating a culture of quality supervision. A Greater Northern Australia Regional Training Network (GNARTN) Project with Flinders University, Darwin, Australia

ISBN: 978-0-9942199-0-9

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1. INTRODUCTION

Work-based peer review of clinical supervision practice is an approach that assists in creating an organisational culture of quality supervision. Clinical supervision is a key element of best practice governance frameworks in health care (HETI, 2014). Recent Australian health workforce strategies have invested heavily into clinical supervision training through the Clinical Supervision and Support Training program (Health Workforce Australia, 2011). These strategies primarily revolved around provision of workshops (e.g. Campbell, Wozniak & Lenthall, 2013).

Applying the learning from workshops may be enhanced when professionals have the opportunity to share their learning and implement new strategies using a cycle of continuous quality improvement. This can frequently be more difficult for rural and remote clinicians because they are geographically dispersed and isolated from professional peers. One way to overcome this is to develop an interprofessional support strategy that creates a workplace climate to support peer review of clinical supervision (see Figure 1).

Clinical supervision is strengthened when individuals utilise a peer review process as part of their commitment to continuing professional development. Peer review of clinical supervision is a multi-layered process whereby a peer reviewer collaborates with a clinical supervisor (reviewee) to enhance an area of their clinical supervision practice. This may involve observation of the clinical supervisor as they supervise learners as shown in Figure 1 (see Appendix 1 for further explanatory definitions). Therefore, peer review of supervision can contribute to a cycle of workplace quality improvement.

Peer feedback has several advantages over feedback from learners or from other non-peer observers (such as supervisors or other evaluators). First, the observers benefit by gaining insight into their own weaknesses and potential areas for growth as teachers. Additionally, collegial observation and feedback may promote supportive teaching relationships between faculty. Furthermore, peer review overcomes the biases that may be present in learner evaluations. (Mookherjee, et al. 2014, p245)

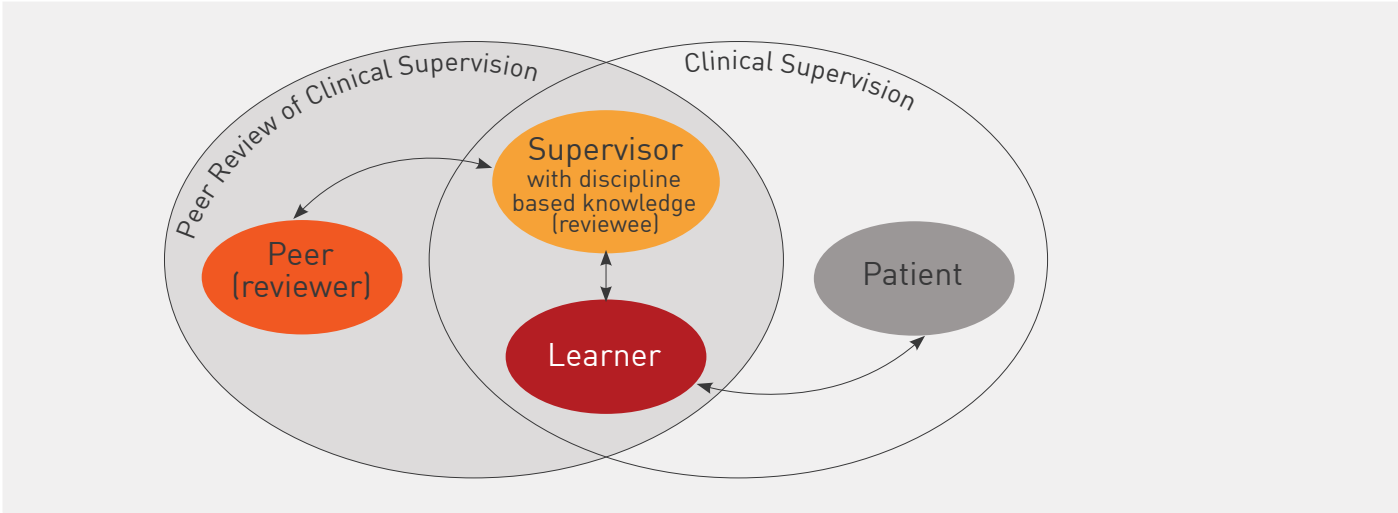

Figure 1: The relationship between peer review of clinical supervision and clinical supervision

Mookherjee, Monash, Wentworth, & Sharpe (2014) recognised the importance of linking professional development supervision-related activities with ongoing workplace strategies. They noted that supervisors attending professional development workshops isolated from the workplace may attempt to apply what they learnt to their practice, but struggled to get feedback about their actual workplace supervision practices. Further they recognised the importance of providing an avenue for enhancing clinical supervision practices in the work environment and so developed a workplace-based peer review process. The outcomes indicated that participants gained improved confidence in teaching behaviours and did not find the process of peer review with their colleagues difficult.

This guide aims to provide an overview of peer review of clinical supervision and provide strategies to implement it in your workplace. It was developed following a review of the literature and resources from a range of professions including health, higher education and other teaching environments to identify themes, tools and frameworks that would be applicable to peer supervision in the rural and remote health care environment. The methodology is outlined in Appendix 2.

HOW TO USE THIS GUIDE

The flow chart shown in Figure 2 outlines how to use this guide to develop your own peer review of clinical supervision.

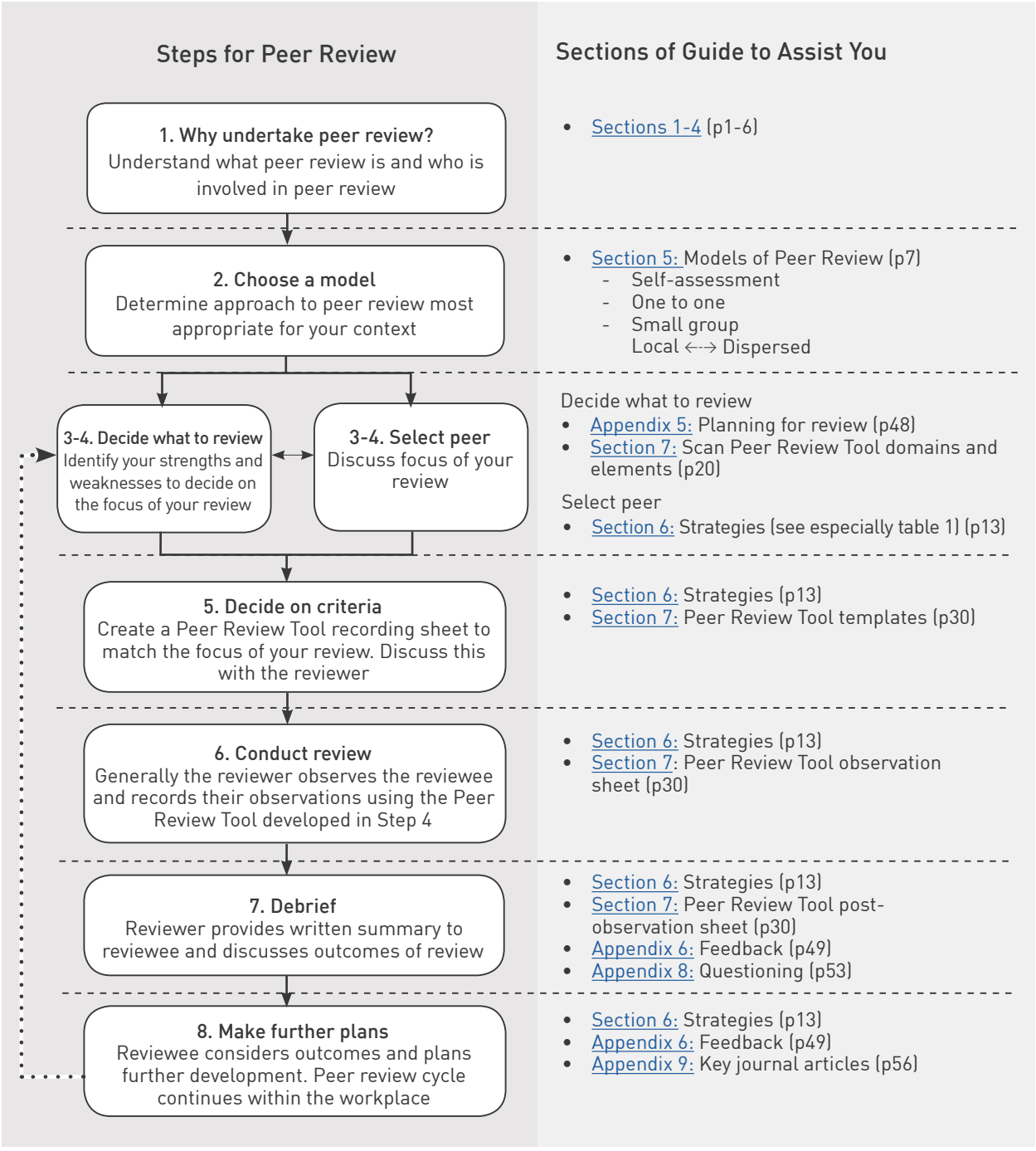

Figure 2: Flow chart showing peer review planning process linked with sections in this guide

2. WHAT IS PEER REVIEW?

Peer review of clinical supervision is a process whereby professionals of the same or different professions work together to observe and critique the clinical supervision practice of the other in order to reinforce areas of strength and identify areas for further development. The focus of peer review determines both who the peer is and what the peer is expected to do and can be thought of as a continuum (depicted in Figure 3). At one end the peer review has an evaluation focus where performance is judged on externally-set criteria. Potentially the person being the reviewer is not truly a peer but likely to be an expert, a manager or an accreditor of competence. If the review has a developmental focus then the review will be conducted by an experienced guide for a junior staff member. The collaborative focussed review is based around mutually agreed parameters between two individuals who are peers in the sense of similarity of experience, expertise or profession. The least structured type of peer review looks more like an informal dialogue with a critical friend (Gosling, 2014).

Figure 3: The continuum of peer review guide

Appendix 3 provides detailed information about the differences between these styles of peer review including the purpose, outcomes, relationships between reviewer and reviewee, conditions for success and risks with each style of peer review.

For the purposes of this guide, peer review is most closely associated with the **collaborative focus** where the review is non-judgemental and based on mutual reflection and dialogue. The collaborative nature of work required in rural and remote areas means that health professionals in these regions may already have some 'natural' peer groupings set up or may need to engage in the peer review process with health professionals outside of their own profession.

Having a collaborative focus means the review is a reciprocal process between colleagues working together to improve the way they supervise by observing each other's practice. It is a collegial, mutually beneficial process in which information about supervision is formulated, exchanged, challenged, tested and reformulated by all parties to improve supervisory practices (Åkerlind & Pettigrove, 1996; Siddiqui, Jonas-Dwyer & Carr, 2007). It is built on relationships, aims to be inclusive and is unrelated to formal supervisory structures therefore providing a reflective space for colleagues to view their supervision role more critically (Metcalfe, Farrant & Farrant, 2010). Often a feedback form or observation checklist guides the process. It is usually between two or three colleagues, or a small group (Bell & Cooper, 2013).

Peer review is a voluntary system of professional support that can assist supervisors at any stage in their career to gain valuable insights into their supervisory practice within a confidential, caring climate. (adapted from Gosling, 2005)

The key elements are feedback and reflection (Finn, Chiappa, Puig & Hunt, 2011) underpinned by formative exchanges between colleagues collaborating together over time to improve their supervision practices. Thus it is a dialogue between critical friends who support each other by exploring the consistencies between the theory of clinical supervision, their beliefs about clinical supervision, and their practice. This type of partnership helps to develop the habit of individual and collaborative, critical reflection (Bell & Cooper, 2013).

UNDERLYING PRINCIPLES FOR PEER REVIEW

Peer review processes are most effective when they are based on a number of important principles (Timberlake, 2009; Centre for Learning and Development, nd):

- participation should be voluntary
- acknowledgement that there is no ideal way to supervise
- processes should be flexible- involving negotiation about what to review, how it is to be done, how feedback is to be given and what it will be used for
- focuses on all elements of supervision not just student to supervisor encounters
- provides collegial feedback which enables reflection
- allows for different supervision needs in different disciplines
- focuses on improving quality of supervision to improve learning
- recognises that improvement is incremental

It should be noted that peer observation is a closely related term also used in the literature. This describes a process whereby a colleague watches another colleague engaging in a supervision related activity without necessarily being required to give feedback. Instead they are learning from being immersed in the colleague's supervision situation. In this case it may not involve dialogue, rather just personal self-reflection about the observed experience (Hendry, Bell & Thomson, 2013).

3. WHY IS PEER REVIEW IMPORTANT?

Clinical supervision is usually a duty that is added onto the main role of patient care for health professionals. Health professionals are generally prepared for working in health care settings, but often have not had training in how to educate others and supervise learners so they tend to base their style on previous experiences of being taught and supervised (Finn et al., 2011). Clinical supervision requires additional skills other than professional content knowledge and becomes even more challenging in the rural and remote context where establishing and developing workplace supports can assist in retention of staff (Mills, Francis &Bonner, 2005). It includes such non-cognitive skills as relationship skills, understanding personality, reading non-verbal communication and emotional states.

Supervisors can get feedback from learners to enhance their supervision practice however this has some limitations. Students may not provide a balanced viewpoint due to the power differential between student and supervisor. They may fear that their feedback could influence assessment of their performance (Gusic, Hageman & Zenni, 2013). Additionally student feedback is often provided at the end of a placement and therefore disconnected from the learning event (Mookherjee et al., 2014). Certainly global feedback from learners can provide insights into areas for improvement however it does not easily provide specific guidance or facilitate action.

There are a number of benefits from engaging in peer review of your supervision practices. These include broadening your approach by sharing viewpoints with interested colleagues, raising awareness about quality supervision, and improving the climate of supervision in your organisation.

BROADENING SUPERVISORY PRACTICES

Observing others supervise provides an opportunity for the observer to engage in self-comparison which leads to reflection about one's own supervisory practice (Finn et al., 2011, Goldsmith, Honeywell & Mettler, 2011). Even when direct observation is not possible engaging in discussions about supervision with peers from other disciplines provides access to varied modes of supervision and exposure to diverse practices (Bailey, Bell, Kalle & Pawar, 2014). These discussions can inform aspects of clinical learning which extend beyond the actual supervision. This can include identifying how the environment itself might support or hinder learning, and areas requiring further development. Gusic et al., (2013) reported that supervisors engaged in peer review were inspired to explore other approaches to supervision and seek out further opportunities to improve their supervision practice. Where near peers are less available in rural and remote settings it might be necessary to engage with peers from other professions, co-opt visiting staff or utilise a more dispersed model [see section 5].

I've been teaching for 35 years and this is the first time I've ever been observed by a peer focused on my teaching role. Thank you. ...It's good to know I am doing some things right along with things I can improve. (Finn et al, 2011, p154)

RAISING AWARENESS ABOUT SUPERVISION

By focusing on supervision and learning in the workplace, engaging in peer review can help supervisors to consider what is expected in this role. It creates a frame of reference for the supervisor as they reflect on what constitutes good supervision and how their own supervisory practices measure up (Fluit, Bolhuis, Klaassen, Visser, Frol, Laan & Wensing., 2013).

Gusic et al., (2013) found that clinical teachers engaged in peer review found the process valuable. They gained information that affirmed good supervision but were also prompted to be more focused on teaching. They reported being more motivated to enhance their teaching by being more deliberate, interactive and learner-centred and more aware of the educational level of their learners.

IMPROVING THE SUPERVISORY WORKPLACE CULTURE

Regular and widespread peer review can result in workplace supervision culture change (Finn et al., 2011). This can be achieved by either top-down governance or bottom-up initiatives. Both will result in a culture of life-long learning and commitment to quality. Those involved in the peer review process become advocates for the process which further strengthens the supervision culture in the workplace (McLeod, Steinert, Capek, Chalk, Brawer, Ruhe & Barnett, 2013). The importance of supervision is flagged across the organisation and positive working relationships can result (Timberlake, 2009).

[Clinical] teaching has come to be recognised as a skill associated with, but separate from content expertise. (Wilkerson and Irby 1998, p388)

By providing time to engage in a peer review process and meeting to share thoughts and ideas or talk about common issues, staff are able to share their experiences and work together to improve supervisory practices (George & Haag-Heitman, 2011; McLeod et al., 2013). By encouraging a more open supervision culture, where discussion and sharing of ideas about supervisory practice is the norm rather than the exception, it becomes more commonplace and embedded into the culture of the organisation.

4. FACTORS THAT MITIGATE AGAINST PEER REVIEW

Just as every workplace is different with a range of priorities and mix of health professionals it is important to recognise that the peer review process should be adapted to the local environment. Awareness of issues known to impact the peer review process will enable the workplace to recognise if these barriers are present and determine strategies to address them. Avenues for overcoming the limitations or barriers need to be considered and support provided for employees to manage them.

The following factors have been identified as impacting on the conduct of peer review in the workplace:

- Workload and time constraints are known to impact peer review processes so it is important to adopt a model that will best meet the needs of the workplace (Beckman et al., 2003). The peer review process needs to fit in with workplace plans and timeframes. The logistics of making time for pre-observation discussion, observation and post-observation discussion needs to be factored into work activities (Gusic et al., 2013, Sullivan, Buckle, Nicky & Atkinson, 2012).
- Fear or apprehension may occur if the peer review process is associated with promotion or performance review (Finn et al., 2011, Sullivan et al., 2012), which is why the evaluative approach is not suggested as the approach to be taken (see Section 3 and Appendix 3). Fear of the unknown can also prevail in the early stages of implementing a peer review strategy as staff maybe nervous about what will happen with the results or if they will be used for judgemental purposes (Carroll & O'Loughlin, 2014). It is important to communicate the model to all staff so a culture of collaboration rather than power and competition can be fostered in the workplace (Bailey et al., 2014).To minimize these factors it is suggested that organisations follow the implementation strategies outlined in section 6.
- Lack of training by those engaged in the peer review process can cause problems (Yoo & Chae, 2011). The Peer Review Tool outlined in section 7, together with this guide, aims to provide a focus for the peer review process and help those new to peer review.
- Mandating the process can lead to apathy and cynicism as this is seen by staff as management policing the process (Murphy-Tighe & Bradshaw, 2013). It is therefore recommended that peer review be a voluntary process.
- Section 5 will provide a range of models that could be adopted by the workplace which will assist in overcoming these barriers to peer review.

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The 10 Commandments of Peer Review (adapted from Spencer, 2014)

1. *Consider the organisational culture before implementing peer observation of clinical supervision*
2. *Distinguish between "Observation" and "Review"*
3. *Be collaborative in your approach to peer review of clinical supervision*
4. *Clearly define tangible outcomes from peer observation of clinical supervision*
5. *Keep the process simple, flexible and accessible*
6. *Honour collegial, constructive and continuous feedback*
7. *Protect the participants' ownership of the process*
8. *Reward participation in peer observation of clinical supervision*
9. *Do not forget the students*
10. *Practice what you preach -evaluate, reflect and continuously improve peer review of clinical supervision*

5. MODELS OF PEER REVIEW

The literature on peer supervision in the workplace suggests that there are a number of models that can be effective. The common foundation of all models is that they are designed to prompt reflection and subsequent action. Inherent in all peer supervision models is the selection of a peer or peers to provide feedback on selected aspects of observed or described supervision processes. Therefore goal setting, observation and reflection are integral to the process of peer supervision.

Peer review assumes a level of homogenous power[1] between both the reviewer and the reviewee. It is therefore different from an expert review where the reviewer may possess additional training, have extensive experience or be a recognised leader (Peyre, Frankl, Thorndike & Breen, 2011).

Experiential learning underpins peer review. Figure 4 below is the familiar reflection or learning cycle, originally conceptualised by Kolb (1984) to describe how people learn from experience. Effective peer review models, even ones relying on self-assessment alone, need to include the key components of experiential learning. These components are:

1. Pre-supervision reflection and goal setting
2. Observation of the supervision encounter
3. Post-supervision reflection, analysis and goal setting to drive future encounters

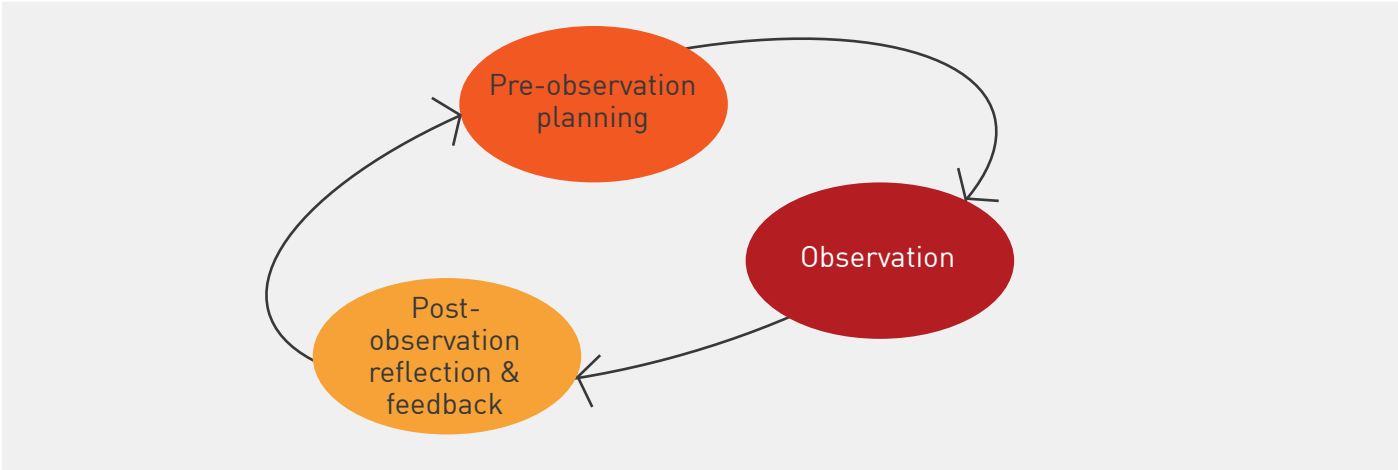

Figure 4: Schematic representation of peer observation of supervision

In the rural and remote context, professionals may not have easy face-to-face access to a peer from their own discipline. It should be remembered that peer review of supervision does not necessarily require the peers to be from the same profession. Thus two professionals could be on the same team but from different professions. The important point is that the aim of the observation is planned in advance between the peers and sufficient context provided such that the reviewer can observe the supervision from a perspective that is informed by the needs of the reviewee.

The purpose of the observation and the number of observers influences the model of peer review selected (Siddiqui et al., 2007). The following section details the range of peer review models including the self-assessment, one-on-one observation, small group and dispersed model. Professionals working in rural and remote workplaces should carefully consider which model will best meet their needs, in particular taking into consideration whether they are best served by seeking a same profession peer- which may require using the dispersed model, or whether they can gain rich feedback by utilising the expertise of peers from different professions who are located in their workplace or who regularly visit their workplace. The self-assessment model which is presented first, can assist in this decision-making because of its role in refining the objectives of the review.

[1] In this context power is defined as the absence or presence of equality in a relationship (Holfstede et al., 2010)

THE SELF-ASSESSMENT MODEL

Self-assessment requires the user to articulate their lived clinical supervision experience (van Manen, 1997) and critique their own practice. Ideally self-assessment would never be done in isolation but rather used as a first step in the peer review process. Self-reflecting on supervision strengths and gaps in knowledge and skills provides a foundation that observation by peers can build on. A self-assessment guide or tool assists the user to identify areas of supervision strength and weakness. Self-assessment could be thought of as like looking in a mirror (Fluit et al., 2013) and gaining insight. Subsequently these insights can be used in discussion with the peer. They become the foundation of the observation and goal setting and therefore ultimately drive personal development and reconceptualisation of what it means to supervise (Åkerlind & Pettigrove, 1996, p55).

Writing can help clarify thinking. In higher education it is common to have to articulate a Philosophy of Teaching. This type of reflection – your Philosophy of Clinical Supervision could be added to your portfolio as evidence of professional development.

One word of caution about self-assessment: It has been shown that self-assessment generally produces more severe or negative ratings than assessments by others (Fluit et al., 2013). Following self-assessment with a peer review can then be a helpful moderator.

Self-assessment can be formal or informal. An informal self-assessment could use a series of open-ended questions to guide reflection and thinking. For example[2]:

- What are my strengths as a supervisor?
- What are my limitations?
- What do my learners perceive as my strengths and limitations?
- What have I done to improve my supervisory practice?
- How would I define my approach to supervision?

These are very broad questions that give a solid overview of supervision practice. There are also more detailed tools.
The Peer Review Tool for Clinical Supervision developed for this project (see section 7) provides a series of descriptors for different aspects of clinical supervision that could be used to assist in the self-assessment process. This would help identify important focus points for the peer review.

In addition the Clinical Supervisors Self-Assessment Tool (HWA, 2014a) (CSSAT), based on the Health Workforce Australia National Clinical Supervision Competency Resource (HWA, 2014b), was designed to assist health professionals and their managers to identify training needs related to student supervision in the workplace. It requires the user to identify their knowledge, skill and confidence in performing tasks considered to be core supervision competencies. Although designed originally as a professional development goal-setting exercise to be undertaken with the support of a manager, it could equally be used by health professionals seeking to drive their own supervision expertise. All items in the tool are generic and therefore applicable across professions. The tool encourages reflection and promotes identification of both strengths and gaps in supervision ability. For each item, the user rates themselves on a three point scale: able to perform the task, requires support to perform the

[2] Adapted from Timberlake 2009

task or unable to perform the task. As a self-assessment tool, it can be completed in less than 15 minutes. Once completed, the answers can be used to create goals for development - short and longer term. Additionally the insights gained may guide the choices about the type of interaction selected for an observation and the goals and outcomes desired from a peer review process.

The tool is available from http://www.hwa.gov.au/sites/default/files/HWA_Clinical-Supervision-Self-Assessment-Tool_HR-VL.pdf

Another useful guide for self-reflection was developed by Fluit et al., (2013). This study developed and validated a tool, the EFFECT (Evaluation and Feedback for Effective Clinical Teaching instrument). The tool aimed to comprehensively assess the domains of clinical teaching and has interprofessional application despite originating in medicine. The EFFECT tool is comprised of a number of observable tasks or points grouped into seven domains. The domains are Role modelling, Task allocation, Planning, Feedback. Teaching methodology, Assessment, and Personal support. Besides being a useful 'list' of the types of activities that occur in clinical supervision, the tool could be used as the basis for a written self-reflection that examines personal supervision strengths, gaps and goals. This self-reflection could be provided to the peer reviewer or retained in a portfolio of evidence relating to personal development of supervision expertise. Appendix 4 outlines the EFFECT tool in further detail. Elements from both the EFFECT and CSSAT tools were utilised in the development of the Peer Review Tool for this project.

Potentially self-assessment could also include self-observation. This would require video-recording of a supervision session. The session could then be watched and reflective writing used to set goals for follow up sessions. Alternatively you could ask a peer to review the video recording. Consent for videorecording must be gained before using this strategy.

In summary, self-assessment of clinical supervision strengths and weaknesses promotes personal reflection which can be used for setting supervision development goals. It assists the supervisor to gain insight that they can use immediately in their supervision practice. It also adds value to the peer review process. The results of the self-assessment may be usefully shared with the peer reviewer or used to guide the setting of goals for the actual observation (see Section 6).

It's natural to be self-conscious about seeing and hearing yourself on screen. Once you've done it a couple of times you will be able to move past the awkwardness and focus on critiquing your supervision practice.

THE ONE-TO-ONE OBSERVATION MODEL

The most straightforward peer observation to set up is a one-to-one model. In this model, the purpose of the review is decided, the peer is selected and a plan initiated. Ideally the review process will be reciprocal so that each acts as reviewer/observer and reviewee/observed.

Observing a peer undertaking supervision has been reported as highly valuable (Finn et al., 2011, Centre for Learning & Development nd). So the purpose of an observation may be simply to benefit the observer. The observer may be a new supervisor, someone lacking in confidence or struggling with supervision practice. They might wish to reflect on their own practice and learn by observing another clinical supervisor in action. In this case they are not functioning as a peer reviewer per se, as feedback to the person being observed is not part of the negotiated milieu. In this situation the observer gains insights into how someone else supervises which can help calibrate quality standards of supervision and gets ideas they may wish to implement in their own supervision.

A peer will be a colleague who is active in patient care and teaching responsibilities... and [who will] provide feedback based on their observations. (Peyre et al., 2011, p373)

The one-to-one model has a distinct advantage over self-assessment alone because it provides additional information. The reviewer can observe and provide feedback on the supervision process as well as the impact of the supervision on the learner (Farrell, 2011).

The peer review relationship requires collegial structure and should not be conducted in a haphazard way. Decisions need to be made about a number of factors including whether the relationship is a reciprocal one, as well as the structure and purpose of the review and an agreed timeframe (Smith, nd; Mookerjee et al., 2014, Metcalfe et al., 2010). Clarifying the type of feedback to be provided is also important.

Most people in the early stages of a peer review process are likely to select sessions for observation that showcase their strengths. However as trust in the peer grows, more difficult supervision situations may be selected. It is important in this situation, to specify the goals of the observation and additionally to articulate areas of observation that may be particularly sensitive, confidential or 'off-limits'. This should include a discussion about what role the peer reviewer should take should the observed encounter become highly emotional or difficult. Incorporating observation checklists, personal goals and feedback to the observation will increase the value of the observation immensely. Results from the Peer Review Tool included as part of this guide, or the CSSAT or EFFECT can be usefully used in pre-observation discussions and followed up in post-observation debriefing.

Peer review involves informed and formative exchanges between colleagues on every aspect of what they do to help learning to occur. Peer reviewers work together to improve the way they work individually with and for students. Under ideal conditions they do tis collaboratively over a period of time. (Åkerlind & Pettigrove, 1996, p13)

Ideally the peer reviewer should have some training however this may not always be practical. The value-add from training is the additional expertise the peer reviewer gains. Training may comprise a self-development package such as this guide and the Peer Review Tool, or it may be a program developed by the workplace. See Appendix 7 for a list of online resources relevant to clinical supervision.

THE SMALL GROUP OBSERVATION MODEL

Like the one-to-one model, in group peer supervision, the stages of the experiential learning and reflection cycle apply. This means that a pre-observation meeting to select goals occurs before the observation and post-observation debrief must also be scheduled. This meeting provides feedback and opportunity for 'interactive reflection', and facilitates the person being observed to apply their learning. The size of the peer group providing the observation needs to be considered.

One model of small group observation reported in the literature recommended a group of three peers (Goldsmith et al., 2011). One acts as the reviewee, i.e. the person being observed, and the other two are the peer reviewers. The value of multiple observers is the varied perspectives they offer. While a small group may be more difficult to achieve in rural and remote regions, interprofessional workplace groups may be both possible and enable productive outcomes.

Finn et al., (2011), Goldsmith et al., (2011) and Bailey et al., (2014) all described successful peer review of clinical supervision programs that used group observation or discussion. The key to their success appears to be that the programs were initiated and purposefully designed to meet the needs of a specific group, a health team with responsibility for supervising novices in training. In-house programs like this can simplify the logistics of the observation and build trust between team members, while also revealing expertise that other members can capitalise on. Resources such as one-way viewing windows can reduce the 'performance anxiety' associated with being observed by a group. However some health professionals regularly and visibly supervise in 'public spaces' such as teaching rounds so negotiating feedback from peers already participating in this work space may be straightforward.

Finn et al., (2011) reported a successful and sustained peer observation of teaching program. Centred on the typical 'ward round' scenario within medicine, a clinician educator not on clinical service became a silent observer on the round. The observer's role was to comment on 'team dynamics, bedside teaching, feedback given, teaching styles and techniques, time management and engagement of the team in the discussion' p152. Interestingly the observer did not use checklists or have specific training. After the round, the observer provided verbal feedback. The feedback included both specific effective supervision examples and those that offer opportunity for change. A summary of the feedback was then written up and stored electronically in a central place. One take home message from this type of approach to peer review of supervision that can be applied to rural and remote workforce is that informal and simple approaches can be successful. Successful peer review will result from a close examination of the opportunities available in the workplace and this will potentially be work-place idiosyncratic.

Key aspects to group observations reported by Bailey et al., (2014) included structuring the pre- and post-observation sessions for reflection using a solution-perspective. Additionally it was found important to intentionally allocate time to evaluate the group process so changes can be incorporated into future observation sessions. It was not thought necessary to have an appointed facilitator or group leader although groups may prefer to nominate someone to this role.

Finn's program goes against most of the other literature regarding the essential components of a peer evaluation process. In particular the pre-observation negotiation of goals and learning outcomes is missing.

- *What do you see as the risks of this type of approach?*
- *Would this type of process suit your workplace?*
- *Does your workplace currently have sufficient capacity to commence a program like this?*

For workplaces interested in creating a culture of quality supervision in the workplace, and planning to implement a group peer model, the first step would be to collectively meet and make some decisions about how to proceed. In particular discussion could include:

- access to resources such as readings, online training modules,
- design of tools to record observations,
- who is going to participate,
- the timeframe for the review process
- what needs to happen next?

Section 6 provides more details.

THE DISPERSED MODEL

Participating in a dispersed model of peer supervision might be the only option for some health professionals. Health professionals in remote areas or with limited access to co-located peers may opt for this model. Essentially it means using videoconference (VC) or other internet based platforms such as Skype rather than being face to face. Using internet reliant mechanisms have additional complexity but can still achieve the goals of the peer observation either being conducted in real time or as a saved recording for later viewing by a peer (Romeo, Gronn, McNamara & Teo, 2012). Another alternative could be to use the video and audio recording capabilities of mobile devices to capture the clinical supervision event although this would require permission to be sought from the learner and patient (see below for further suggestions).

Participants need to decide on the method most suited to their environment as well as finding out if there is support or training to use the equipment and troubleshoot technical problems. This may also include investigating whether the internet bandwidth is sufficient.

If utilising VC options the location of the equipment itself also needs to be considered as this will influence decisions about how the observation is managed. Access to VC equipment in the room where the supervision occurs would be ideal. This may be available in some facilities such as simulation labs or purpose-built training clinics. Some VC units are on mobile trolleys which can be moved to the location of choice. As noted above alternatives would be for participants to video or audio record their supervision/teaching interaction and provide this to their peers for reviewing and discussion. Whichever is decided it is important to maximise the quality of the audio and perhaps consider using an external microphone (Romeo et al., 2012). A less ideal alternative to live supervision via VC would be to share written reflections on the supervision event for discussion and feedback with peer/s.

Like all observations of supervision, consent from all parties involved is essential however using the dispersed model does require an additional step. If recording the encounter, then explanations about how the video will be used, who it will be shown to and where it will be stored are important. If the observation is live via the videoconference then all involved need to understand who is observing and why they are included.

It can be more difficult to build trusting relationships using a VC model (Marrow, Hollyoeke, Hamer & Kenrick, 2002) and potentially the complexities can contribute to a loss of commitment to the process. The persistence and motivation of the professionals involved will be an important factor in whether this model produces a satisfying outcome (Marrow et al., 2002).

6. STRATEGIES

This guide is not suggesting a prescriptive approach to peer supervision however it is important to recognise the importance of forward planning. Peer supervision is unlikely to occur opportunistically. Ad hoc peer observation will benefit the individuals involved however greater commitment and satisfaction from the process will occur if a plan is made that is supported by the broader organisation (Harris, Farrell, Bell, Devlin & James, 2008). Making peer observation of supervision mandatory will not necessarily result in better outcomes than a process which is voluntary (Siddiqui et al., 2007). The best outcomes occur if a culture of quality supervision is supported and valued in the workplace.

This section provides detail about the strategies you can use to implement a successful peer review of your clinical supervision activities. Although these strategies are presented in a linear way, they do not form steps per se. Many of the strategies are overlapping and complementary, and can be considered concurrently. As shown in Figure 5, each contributes to the outcome of quality supervision practice. The order that you undertake the strategies will vary according to your personal preference, the organisation in which you work and the opportunities available to you.

Figure 5: Strategies contributing to peer evaluation of supervision

MAKING A PLAN

The literature suggests that the culture of quality peer supervision develops over time (Finn et al., 2011). Regardless of whether the peer review of clinical supervision program is one-to-one, small group or dispersed, there are a number of common elements to consider. In general, answering a series of 'wh' questions: who, how, when, where, why, and what effect do we want from peer review of clinical supervision will go a long way towards planning for a successful outcome (Åkerlind & Pettigrove, 1996). (Appendix 5 contains Åkerlind & Pettigrove's list.)

In order to maximise success you might decide that in the next 12 months you will complete two observations as reviewer and two as the person being reviewed. All observations will be scheduled during your usual supervision activities rather than being an add-on.

- Committing to a time frame or set number of observation sessions will result in better outcomes. Busy people will naturally have concerns about how to find the time for peer observation.
- The best plans will be those that are simplest to implement. Think about how the peer observation could fit into the settings where you normally teach (Gusic et al., 2013). This could include ward rounds, 'bedside' tutorials, outpatient clinics, giving feedback to a learner on assessment results.

CLARIFYING THE PURPOSE OF THE REVIEW

The purpose of the peer review and observation will guide a number of decisions. Potential purposes could include improving teaching, troubleshooting, or supporting an application for award or promotion. Peer reviews are often thought of as live observations of teaching. In this situation the decisions that need to be made include:

- The **context** of the supervision sessions including any background material or information you could provide to the reviewer prior to the session.
- Who the learners are and what are the **learning outcomes** for the session.
- The role taken by the reviewer (passive, shadowing), where the reviewer should physically be in the room, how you will introduce the reviewer to others present (learner/s, patient, family).
- Your **expectations** about feedback- type of feedback; specific criteria or checklists that you would like used; how you intend to use the feedback; confidentiality of the session contents and the feedback. The Peer Review Tool (Section 7) can assist you to determine what aspects you would like to focus on for your peer review.
- Remind the reviewer to focus not just on what was observed but also to comment on your **educational approach** to the session.

Not all peer reviews have to be live observations. You might select other aspects of supervision as the topic for review. This could include how you organise your workplace for learners, how you prepare your learners, orientation materials, other resources you use or have developed including assessment guides or simulation scenarios for example.

DEVELOP A CLIMATE OF TRUST

Everyone involved in peer supervision will gain maximum benefit if a climate of trust is created (Harris et al., 2008, Marrow et al., 2002). Feeling in control of the process confers ownership to the person being reviewed and allows them to focus on potential positive gains rather than feeling it is 'one more thing' that they have to fit into an already crammed work-day (Metcalfe et al., 2010). Unless the review is for performance appraisal purposes, workplaces may prefer an 'opt-in' peer observation approach (Bailey et al.,2014; Carroll & O'Loughlin, 2014). Trust is best established when control is shared by the participants.

A collegial atmosphere of trust and respect where everyone approaches the process in a professional and sensitive manner is essential. All participants must respectfully acknowledge that there is not a 'one size fits all' approach to supervision but rather that diverse approaches provide for richer learning (Metcalfe et al., 2010; Mookerjee et al.,2014).

The notion to sit beside, that is, two professionals working collaboratively, is critical. (Timberlake 2009)

Full disclosure about what will be done with 'the results' of the observation will support trust in the process. Participants need to understand what is confidential between peers, and what needs to be passed to management or other bodies. Understanding whether the results of the observation contribute to a summative or performance appraisal process is important (see Appendix 3 for further details). And finally, discuss in advance what will happen should an incident occur during the observation that requires reporting.

Successful repeated partnerships contribute to the development of trust. If peer review partners are not well known to each other they may wish to take some time to get acquainted (Marrow et al., 2002, p279). This can be easily accomplished by allowing sufficient time to discuss and agree upon the context and goal of the session designated for observation (Metcalfe et al., 2010; Mookerjee et al.,2014).

CHOOSING YOUR PEER

The model of peer supervision selected and the driver of the process will impact your autonomy to personally select the peer. In general the literature suggests that trust is engendered when peer reviewers are known to each other however some experts suggest that the reviewer should be less well known in order to reduce 'mutual back-patting' (Metcalfe et al., 2010).

The role of reviewer is that of critical friend and should identify areas for further professional development, thus benefiting both the reviewer and the reviewee. (Centre for Learning & Development, nd, p2)

The reviewer should be someone who is respected for their sound knowledge or experience about effective supervision practices (Centre for Learning and Development, nd). You want to avoid acquiring 'counter-productive practices from peers' (Centre for Learning and Development, nd, p1). The use of clearly written and observable agreed-upon criteria for observation will off-set the risks that the feedback does not meet your needs.

A key aspect to consider in selecting a peer is whether they are from your own discipline (Peyre et al., 2011). Generally you should be guided by what you want to achieve from the peer review. If the

reviewer needs to understand the content of what you are teaching then it would be sensible to select someone from your discipline.

Table 1: Advantages and disadvantages of various peer reviewers*

Peer	Advantages	Disadvantages
From the same discipline or profession	Will have experience in teaching the same, or related, concepts. May be able to comment of the currency and accuracy of information ('content').	Content focus may distract from the focus on the supervision process.
From the same department/ work area or team	As for disciplinary colleague, with the added advantage of encouraging an open culture of discussion about teaching in the department, between colleagues.	Focus on content may distract from fundamentals, including the effect of the teaching on students.
From a more 'distant' discipline (e.g. radiographer with occupational therapist; surgeon with palliative care doctor; pharmacist with anaesthetist)	Potential for exposure to 'novel' teaching approaches. Reviewer likely to avoid distraction of specifics of the content and instead focus on the core aspects and effects of the teaching.	Reviewer may need more background information in order to understand the context of the interaction.
Experienced in clinical supervision	More likely to understand the 'practical realities' of supervision. Likely to have direct experience of various teaching strategies (although experience is neither necessary nor sufficient for effective peer feedback).	A large difference in 'seniority' can be a challenge to open and collegial feedback (although it need not be).
Experienced in teaching the same group of learners	Knows the learner cohort and their specific needs in regards to curriculum and competencies. May create benefits for better coordination and connections between the learner experiences.	Reviewer can be distracted by the specifics of content. Limits opportunities for introducing new ideas and strategies.

*Adapted from Farrell, 2011.

Hofstede, Hofstede & Minkov's (2010) international research into cultural differences and their impact provided fascinating insights that suggest another consideration when selecting a peer. He developed the 'power distance index' which describes 'the extent to which less powerful members ... of organizations...expect and accept that power is distributed unequally' p61. This suggests that peer review between members of cultures with a vastly different power distance may produce different results than would be expected from members of the same culture.

UNDERTAKING THE OBSERVATION

Guidelines for the observation should be negotiated at the pre-observation planning discussion (see Figure 4 previously). The following list provides an overview of important things that the reviewer needs to have considered:

- Be clear about your role- are you silent, allowed to intervene or make suggestions, is there a place for you to ask questions?
- Be clear about where the observation is taking place and who will be there
- Understand who is going to introduce you and explain your role to the rest of the people present during the observation
- Are there any additional risks posed by your presence?
- Observe the learner and patient reactions, as well as the supervisor, during the encounter
- Note down other interesting observations you made, don't rely totally on the observation checklist that you are using.

It is important that the reviewer records their observations in some way as these will form the basis of feedback (Carroll & O'Loughlin, 2014). These observations will focus on the supervision session itself rather than make personal comment on the supervisor.

Understanding the types of questions that clinical supervisors might ask learners provides opportunity for feedback and professional development. Finn et al., (2011) noted that novice educators asked learners factual questions, whereas more experienced educators asked application, analysis and synthesis questions. Appendix 8 provides a helpful framework for evaluating questions with tips for advanced questioning techniques.

The use of a checklist allows individuals to implement specific new behaviours in future teaching encounters, and when analysed in aggregate can allow an institution to identify potential areas of focus for professional development activities for all teachers. (Gusic, 2013, p290)

ACTIVE ENGAGEMENT IN THE DEBRIEF AND FEEDBACK DISCUSSION

The debrief and feedback session post-observation is the key to closing the cycle of learning and enables the reviewee to develop goals for further development and change (Fluit et al.,2013). It should be developmental in focus with a supportive and constructive approach (Centre for Learning and Development, nd). It is a dialogue between all parties that promotes reflection.

The principles of giving good feedback to learners apply equally to feedback with peers. In a peer review framework, feedback is a means of describing 'what the peer reviewer sees, hears and senses happening in the supervision situation as well as how that fits with what the peer reviewer understands about supervision'. (Harris et al, 2008, p 75). The perspective is that of an honest but supportive 'critical friend'. The feedback should match the goals discussed prior to the observation and the amount of feedback should match the capacity of the reviewee to absorb and make use of it. This means the reviewer should be honest about the issues but 'tender on the person' (Timberlake, 2009, p6). Specific, descriptive feedback allows the person receiving it to apply it to future encounters, to create goals that are achievable and to report back on those goals. In our Peer Review Tool we suggest you provide three items that reinforce positive aspects

of the clinical supervision behaviour you observed and three constructive comments that the reviewee could consider as they develop further goals for their supervisory practice.

Feedback should be provided as soon as possible after the observation and in a mutually-agreed location that assures confidentiality. It may be written or verbal. The value of verbal feedback is the dialogue itself- a mutually satisfying open discussion about what was observed. The value of written information lies in its potential for prompting considered reflection. Additionally it can included in a portfolio demonstrating growth and goal achievement (Carroll & O'Loughlin, 2014).
Actively engaging in the debrief and feedback is beneficial to both the reviewer and the reviewee (Finn et al., 2011; Goldsmith et al., 2011; Lamb, Lane & Aldous, 2013). The reciprocity lies in the value for the reviewer in gaining ideas and subsequently setting goals that enhance their own professional supervision practice. Additionally the reviewer has been reported as gaining confidence in giving useful feedback (Mookerjee et al., 2014).

Forward planning about how to commence the feedback session is useful. Potential questions that could be used are:

- Was this a typical supervisory session?
- What is your impression of how it went?
- What were the strengths and weaknesses of the session?
- What went really well? Was there anything that did not go so well?
- Did you achieve what you wanted to achieve?
- What were the learning objectives for the session?
- Would you change anything if a similar situation was presented?
- What is the main thing you've learned that you could apply to another session?

(Adapted from Timberlake, 2009; Åkerlind & Pettigrove, 1996.)

It is possible that the reviewer may observe things that the reviewee is unaware of - 'blind spots' (Goldsmith et al., 2011). Bringing these to conscious awareness is important for creating change however this needs to be handled sensitively. Weighing up the impact of the blind spot on the supervision will assist the reviewer in deciding how to bring it up for discussion. Being explicit and descriptive about what was observed and the reaction it caused will reduce possible defensiveness in the reviewee.

For example: "I noticed that when you said: 'Well that wasn't a good session, was it', to the student, that they winced and looked away, and then the student was not able to be articulate when discussing their weaknesses."

You might also consider triangulating the information you uncover in the peer review with other forms of feedback such as learner evaluations (Drew & Klopper, 2014; Åkerlind & Pettigrove, 1996). This will increase the meaningfulness of the learner feedback and really assist you in figuring out what the discrepancies between the peer reviewer and learner feedback means.

UNDERTAKING THE OBSERVATION

Participating in a peer review process takes time and effort from both the reviewer and the reviewee. In order to achieve maximum benefit from the process it is suggested that a brief evaluation be undertaken (Farrell, 2011). Something simple such as a three point Likert scale illustrated in Table 2 could be used.

	Agree	Neither agree nor disagree	Disagree
The feedback I received will enhance my supervision			
The peer review process helped me to usefully discuss my supervision with my peer			
The experience of reviewing a peer's supervision will enhance my own supervision			
The experience of reviewing a peer's supervision will enhance my own supervision			

Table 2: Evaluation of peer review of supervision (adapted from Farrell 2011)

Undertaking an evaluation of the peer review that you have participated in completes the cycle of learning and lays the foundation for commencing a new cycle.

IMPLEMENTING PEER REVIEW FROM THE PERSPECTIVE OF THE ORGANISATION

Voluntary participation by individuals in peer review needs to be considered differently to a peer review process that is mandated by the employer. Mandatory participation needs to be accompanied by clear information that clarifies the purpose of the process and therefore addresses how the organisation plans to resource it and use the results (Fluit et al., 2013). Appendix 3 describes the differences between this more evaluative rather than collaborative model of peer review.

There is a lot of value in avoiding rigidity in the processes and inviting employees to participate in decision-making in order to create ownership of the process. This will increase the sense of engaging in an activity that is worthwhile, safe, collaborative and negotiable (Lamb et al., 2013).

Bell & Cooper (2013) suggested four stages to organisational implementation of peer review.

- Stage 1: Initiation- leadership to plan and get agreement, presentation at staff meeting or similar
- Stage 2: Preparation- a workshop or other activities
- Stage 3: Partnerships: the actual peer review including selection of peers, observation, feedback reflection
- Stage 4: Evaluation of process

In another model reported by Mookerjee et al., (2014), a year-long structured peer review program based on the Stanford Faculty Development Program was set up. They found that participation dwindled over the year despite solid commitment from staff. Initial training to commence the program was essential and they suggested a flexible approach of observing 'anyone anytime' might be better than pre-allocated peers in a structured approach.

A review of the literature examining support strategies for rural and remote health care practitioners found that the success of programs in rural and remote regions will be enhanced if there is active involvement of participants in the design of supportive programs, using a marketing strategy to inform participants, leadership, matching the strategy with available resources as well as engaging in regular review and evaluation of the initiative (Moran, Coyle, Pope, Boxall, Nancarrow & Yound, 2014).

7. THE PEER REVIEW TOOL FOR CLINICAL SUPERVISION

PURPOSE AND BACKGROUND

This section presents a tool, the Peer Review Tool (PR Tool) that can guide the peer review process. The tool contains components that will focus the observation and prompt discussion between peers about clinical supervision practices.

A number of different frameworks informed the development of the PR Tool. It is structured around the three overarching domains of supervision activity described in the National Clinical Supervision Competency Resource (HWA, 2014b) (after this called the Competency Resource). The domains are Clinical Supervision, Safety and Quality in Clinical Supervision and Organisation. The Competency Resource was developed by Health Workforce Australia (HWA) to identify and describe the professional expectations of clinical supervisors in the health professions. It aims to assist in the "development of high quality clinical supervision from local level initiatives to wider systems level changes" (HWA, 2014b, p 4.).

The Competency Resource can be used to assess the clinical supervision competency of individual clinical supervisors and also foster a reflective approach to personal and professional practice. (HWA, 2014b p 5)

The competency elements and performance indicators outlined in each of the three domains of the Competency Resource were analysed to identify observable behaviours that could be used to form an observation checklist for the peer review of clinical supervision process.

The development of the PR Tool was also heavily influenced by the "Clinical Supervision Self-Assessment Tool" (HWA, 2014a; Schultz, 2012) which enables self-assessment by clinical supervisors of knowledge, skills or confidence to perform each element in the Competency Resource.

In addition a range of international literature sources enabled cross-checks and refinement. Some of this literature targeted learner, rather than peer, feedback (for example: AlHaqwi et al., 2014: Clinical learning evaluation questionnaire). Where applicable these were modified to better fit a peer review process.

A well-known checklist that informed this tool is the Stanford Faculty Development Program (SFDP-26). The aim of SFDP-26 is to describe high quality clinical teaching. It has undergone extensive validation including modification (Beckman, Lee, Rohren & Pankratz, 2003; Mookherjee et al., 2014). Finally checklists for peer review of teaching in the university context were evaluated to further inform the list of observable behaviours included in this PR Tool (Crisp et al., 2009; Harris et al., 2008).

In keeping with much of the literature (Zenni et al., 2011; Fluit et al., 2012; Gusic et al., 2013; Syndman et al., 2013; Mookherjee et al.,2014), and in order to enhance the usability of the PR tool, observable behaviours were grouped into categories relevant to each of the domains of the Competency Resource. The work of Zenni et al (2011) was particularly helpful in doing this.

Therefore the PR tool is a list of observable behaviours to guide a peer

reviewer or promote discussion between peers about their clinical supervision competency. It is purpose-designed to accompany the peer review process rather than being a self-assessment tool such as that developed by Schulz (2012).

The next section outlines how the PR Tool could be used, then provides detailed descriptors for each domain.

HOW TO USE THE PEER REVIEW TOOL

There are three domains in the Competency Resource: Clinical Supervision, Safety and Quality in Clinical Supervision, Organisation.

The PR Tool is divided into the three domains of the Competency Resource. It is suggested that you **first** review each domain and determine which elements are most appropriate for your peer review process. This will help to focus the review. Some of the items may also be used as triggers for discussion in a pre-observation planning meeting or a post-observation reflection and feedback review.

Reviewing the complete detailed list may stimulate the reviewee or reviewer to identify elements not previously thought about. This will then enrich the peer review process.

Secondly you should either create your own recording sheet using the elements that you wish to include in your checklist or select one of the checklists provided. Template recording sheets and examples are included. They include space for the peer reviewer to write notes during the observation and record overall comments on each element where appropriate. This can then be used to guide the post-observation discussion and promote a more focused peer review process.

Rating scales are not a part of this PR tool because it is difficult to identify graded levels of clinical supervision performance. Additionally research indicates that peers don't "see" the same thing when observing teaching sessions (Beckman et al., 2003). Most importantly, the approach to peer review recommended in this guide is that of the collaborative not evaluative style. (See section 2 and Appendix 3). **Lastly** the detailed PR Tool descriptors may provide a trigger for peer group based discussions about clinical supervision. Clinical supervisors could review the list and identify areas for discussion at a group session. Sharing of ideas and strategies used by other clinical supervisors fosters a collegial environment that supports the development of a collaborative quality supervision culture.

THE PEER REVIEW TOOL DESCRIPTORS

Below is an overview of the PR Tool. It is structured with the Domains (from the Competency Resource), then Elements and finally drills down to bullet point Descriptors (and occasionally sample strategies). Some descriptors apply across domains and in general cross-references have been made to avoid repetition.

Review the list to decide which areas you would like the peer reviewer to focus on. It is not essential to use all these descriptors. They are a guide that you can tailor to best fit your own peer review process.

DOMAINS OF THE PEER REVIEW TOOL

1. CLINICAL SUPERVISION

1.1 Prepare and plan

- Safe learning environment
- Plans learning and allocation of tasks

1.2 Facilitating learning

- Safe learning environment
- Fosters communication
- Models effective clinical patient encounters
- Promotes clinical understanding and retention of knowledge
- Provides constructive feedback to learners
- Assesses student learning
- Promote professionalism

1.3 Problem Solve

- Safe learning environment
- Fosters communication
- Provides constructive feedback to learners
- Promotes professionalism

1.4 Communication- integrated throughout other sections

1

2. SAFETY AND QUALITY IN CLINICAL SUPERVISION

2.1 Safety

- Safe learning environment

2.2 Quality

- Fosters communication
- Promote professionalism

2

3. ORGANISATION

3.1 Integration of supervision and learning activities into clinical practice

- Safe learning environment
- Fosters communication
- Promote professionalism

3

DOMAIN 1 – CLINICAL SUPERVISION

This is the largest domain of the Competency Resource and refers to all activities that enable the learner to engage in experiential learning and contribute to patient / client care. The descriptors are matched to the elements provided in the Competency Resource document and include Preparing and planning, Facilitating learning, Problem solving and Communication.

ELEMENT 1.1 PREPARE AND PLAN

This competency element encompasses clinical supervision activities that clarify roles and the supervisory relationship as well as those that assist the learner to set their learning objectives for the placement.

The Peer Reviewer ascertains that the Reviewee has met the selected descriptors:

SAFE LEARNING ENVIRONMENT

- Informs and negotiates with workplace colleagues in regard to the learner's placement
- Provides learner with information about the placement and other orientation materials that provide an overview of the local context
- Has pre-placement contact with the learner to ensure they are appropriately prepared
- Provides learner with processes and key contact in event of questions/emergency etcetera
- Assists learner to engage with appropriate community-activities/people
- Introduces learner to support people; orients them to site/community

PLANS LEARNING AND ALLOCATION OF TASKS

- Outlines, and negotiates as necessary, with the learner around placement objectives
- Facilitates learner input into the organisation of the activities to be undertaken during placement
- Clarifies learner expectations of the placement and their preferred approach to learning
- Clarifies learner needs in regards to other responsibilities concurrent to placement (e.g. assessment or assignments exterior to placement, university-required tutorial attendance)
- Develops a learning plan which outlines the learning outcomes, strategies to achieve learning outcomes and indicators that learning outcomes have been achieved
- Prepares a timetable to guide learner activities during the placement
- Sets tasks suited to the learner's current level of training
- Reserves regular time to meet with learner
- Adheres to scheduled meeting times with learners

ELEMENT 1.2 FACILITATING LEARNING

This section relates to interactions between the supervisor, learner and clients/patients. It encompasses situations where the learner is observing the supervisor or is actively engaged in patient care. It also includes activities whereby the supervisor is giving feedback to the learner, promoting learner reflection or assessing the learner's progress.

The Peer Reviewer ascertains that the Reviewee has met the selected descriptors:

SAFE LEARNING ENVIRONMENT

- Encourages learner participation. Possible strategies include:
    - Welcomes and demonstrates appreciation of learner's participation
    - Encourages learner to ask questions
    - Promotes learner interaction with the patient by explicit articulation of learner role on the care team
    - Ensures learners demonstrate respect for peer contributions in group-learning situations
    - Promotes learners teaching each other
    - Draws non-participating learners safely into the discussion without "grilling" them
- Provides learning opportunities that extend learner capability and develop higher level skills
- Uses adult learning principles to motivate learner
- Shows enthusiasm, energy and passion for subject matter
- Makes subject matter interesting and shows interest in learner contributions and concerns (this may include accounting for learners at different stages)
- Proactively manages busy clinical learning environment. Possible strategies include:
    - Identifies learning goals for each session
    - Avoids distractions or digressions that interfere with learning
    - Discourages external interruptions during supervised sessions
    - Manages and controls time for session

FOSTERS COMMUNICATION

- Introduces learner to patients ensuring patient understands their role
- Encourages exchanges between learner and patient (learner asking questions of and providing explanations to patient)
- Listens actively, without interruption and non-judgementally to the learner
- Incorporates learner's ideas and comments into the discussion
- Demonstrates culturally appropriate communication skills
- Uses questioning techniques that promote higher order thinking, clinical reasoning and increased cognitive demand (e.g. applying, analysing, evaluating – see appendix 8 for examples)
- Encourages learner reflection and subsequent goal setting on their communication skills

MODELS EFFECTIVE CLINICAL PATIENT ENCOUNTERS

- Directly observes learners' undertaking clinical encounters (examining, treating, educating)
- Demonstrates data-gathering (including history-taking), consultation skills, and interpretation of laboratory, examination or other clinical assessment data.
- Provides an appropriate scaffold of support to learners depending on the task and patient complexity, accounting for patient safety and learner level and confidence.
- Helps learners formulate appropriate questions for the clinical encounter
- Prompts understanding regarding the value of information gathered in a clinical encounter

for further decisions about care

- Briefs learners prior to patient encounter regarding key elements or specific features of consultation/procedure including alternate approaches, informed consent, potential risks/ outcomes et cetera
- Facilitates development of procedural skills and examination/assessment technique. Possible strategies include:
    - Demonstrates the steps involved in performing a procedure.
    - Supervises and observes learner performing procedure
    - Provides feedback to learner on their performance
    - Facilitates multiple opportunities to practice
- Provides learners with practice opportunities including oral presentations, role-play and detailed talking through of encounter, drafts of written documentation. Possible strategies include:
    - Offers opportunities for learner to practice oral presentations, role-play interactions with patients before performing these skills with other members of the team or with the patient
    - Offers opportunities for learner to draft written documentation, consultation request, prescriptions, orders, etc. before completing permanent written document

PROMOTES CLINICAL UNDERSTANDING AND RETENTION OF KNOWLEDGE

- Asks learner to outline their diagnosis, assessment or management plans
- Asks learner to demonstrate clinical reasoning and decision-making skills. Possible strategies include:
    - Discusses reasons for diagnostic and therapeutic decisions
    - Raises stimulating and challenging questions that provoke learners' reasoning
- Prompts learner to succinctly and objectively define patient problems using gathered data
- Teaches learner to synthesise patient problems. Possible strategies include:
    - Periodically summarises data to reinforce key elements of the case
    - Integrates key findings in the patient's clinical presentation
    - Uses data from the patient's evaluation to identify patient's problems/needs
- Incorporates learner's ideas. Possible strategies include:
    - Draws/builds on learner's comments to provide reinforcement or expand concepts
    - Offers opportunities for learner to summarise/define patient problems
    - Paraphrases learner's ideas to summarise patient's problems and assessment.
    - Uses/builds on learner's suggestions to develop evaluation and management plans
    - Provides justification if learner's suggestions are not incorporated
- Assists learner to demonstrate reflective practice. Possible strategies include:
    - Reflects on what has been accomplished and what still may need to be done
    - Acknowledges own knowledge gaps and demonstrates strategies that clinicians use to obtain information/data to ensure provision of evidence-based care
- Shares insights from their own practice and previous experience (relates content under discussion to previous clinical situations; reinforces teaching with clinical examples)
- Reveals broad knowledge-base to learner by appropriate sharing of accurate and current information
- Shows relationships between theory and practice. Possible strategies include:
    - Associates basic science concepts with clinical practice
    - Shares relevant research and explains how it applies to decisions about patient care
    - Cites evidence to support practice decisions
- Directs learner to useful literature (encourages outside reading, evidence-based materials)

PROVIDES CONSTRUCTIVE FEEDBACK TO LEARNER

- Provides specific descriptive feedback
- Encourages learner to evaluate their learning and contribute to feedback
- Explains why the learner was correct or incorrect
- Gives the learner ideas or helps him/her identify strategies to improve in their knowledge, skills, and/or behaviour
- Checks the learner has understood the feedback
- Concludes feedback session with agreed priorities and a plan of action for further learner development
- Gives feedback frequently, (preferably on a regular schedule and as well as ad hoc)

ASSESSES STUDENT LEARNING

- Evaluates the learner's performance using standardised objective criteria or assessment tools or portfolios
- Stimulates the learner to be well prepared for any learning reviews
- Provides an opportunity for a learner to identify their level of performance
- Explains how the assessment will be used in placement completion decisions
- Evaluates learner's underpinning factual knowledge such as basic sciences
- Evaluates learner's ability to analyse or synthesise medical knowledge
- Evaluates learner's ability to apply knowledge to specific patients
- Determines if the learner has met specified learning objectives
- Seeks support from colleagues and/or university if any conflict of interest or concern about learner progression

PROMOTES PROFESSIONALISM

- Shows respect for learner and patient. Possible strategies include:
    - Communicates with all learners and patients
    - Uses learner's and patient's names
    - Is sensitive to learner's individual interests and abilities
    - Is aware of and sensitive to learner's and patient's cultural backgrounds
    - Welcomes learner and patient discussion of concerns
    - Answers all questions
    - Incorporates patient values/preferences into clinical decision-making
- Recognises own limitations of knowledge and skills and shares these appropriately with learner
- Integrates discussions and teaching of ethical values and beliefs that guide patient care
- Shares insights about profession's relationship to society including the clinician's role in the community/society/the health care system
- Guides learner's understanding of relationships between health professionals in the team
- Shares insights about profession's relationship to society including clinician role in the community/society/the health care system
- Demonstrates mature approach to managing personal emotions and interpersonal conflict or tension
- Aware of and sensitive to learner's cultural backgrounds

ELEMENT 1.3 PROBLEM SOLVE

This section refers to activities where the clinical supervisor identifies learner issues and develops strategies to manage these issues and support the learner. This section builds on descriptors outlined in Section 1.2.

The Peer Reviewer ascertains that the Reviewee has met the selected descriptors:

SAFE LEARNING ENVIRONMENT

- Adapts teaching strategies to support different approaches to learning and match learner capabilities
- Identifies learner issues that may put them at risk of not completing the placement successfully
- Guides and supports the learner with their patient care plans and deals professionally with any mistakes made
- Recognises when a learner is in stress and requires additional support
- Sets aside time when the learner requires additional support
- Recognises when the learner's difficulties require support beyond the supervisor's expertise and sources appropriate support
- Considers possibility that cultural issues may be a contributor to poor learner performance

FOSTERS COMMUNICATION

- See Section 1.2 (p24) also
- Has strategies in place for managing challenging behaviours such as procedures for documenting discussions with learners about these behaviours (e.g. learner action plan)
- Alert for 'hidden' causes for learner difficulties including clinical competence, professionalism, personal or communication issues

PROVIDES CONSTRUCTIVE FEEDBACK TO LEARNER

- See Section 1.2 (p26) also
- Assists learner to identify strategies to improve knowledge, skills, and/or behaviour
- Provides alternative methods of developing clinical competence such as role play or simulation
- Provides assistance to learners in organising and managing workload
- Concludes feedback session with agreed priorities and a plan of action to improve student performance
- Ensures agreed goals and progress towards these are documented
- Transparent with learner about consequences of lack of improvement

PROMOTES PROFESSIONALISM

- Shows respect for learner by listening to concerns and responding to all questions
- Recognises own limitations and seeks advice regarding management of learner issues
- Helps and advises learner on how to maintain a sustainable work-study-life balance

ELEMENT 1.4 COMMUNICATION

In The Competency Resource, Communication is a separate element however in keeping with the important and pervasive nature of communication skills, in this PR tool it has been integrated within each element (labelled as the descriptor "Fosters Communication" rather than separated out as a separate element).

DOMAIN 2 – SAFETY AND QUALITY IN CLINICAL SUPERVISION

This domain refers to activities undertaken by clinical supervisors that ensure quality health outcomes for clients/patients when learners are participating in their care. It ensures that ethical, professional and legal standards are maintained and learners gain clinical experiences in a safe learning environment. It also refers to strategies used to ensure that the clinical supervision provided is provided at the highest level of quality.

ELEMENT 2.1 SAFETY

The Peer Reviewer ascertains that the Reviewee has met the selected descriptors:

SAFE LEARNING ENVIRONMENT

- Ensures staff at the placement understand the boundaries of practice or expected knowledge of the learner
- Supports the learner to understand and adhere to boundaries of practice
- Understands the learner's level of development in order to balance the need for increasing independence with appropriate level of supervision
- Only intervenes when necessary for patient safety
- Supports the learner to articulate their comfort/discomfort with the level of supervision

ELEMENT 2.2 QUALITY

FOSTERS COMMUNICATION

- Elicits feedback on his/her performance from learners. Possible strategies include:
    - Solicits learner feedback and suggestions for improvement about supervision provided
    - Modifies approach to supervision or teaching in response to feedback
    - Seeks advice from colleagues when supervision challenges need clarification or are causing confusion
- Engages in team based reflection about clinical supervision undertaken at workplace. Possible strategies include:
    - Schedules meetings to enable supervisors to share their experiences
    - Shares feedback about the learner's experience in the clinical setting with colleagues
    - Identifies areas where clinical supervision practices can be improved
    - Engages in team based activities to enhance supervisory practices in the workplace
- Demonstrates culturally appropriate communication skills. Possible strategies include:
    - Explains local cultural practices and norms
    - Provides access to cultural guides
    - Uses interpreters
    - Sets up a cultural mentor for the learner

PROMOTES PROFESSIONALISM

- Conducts supervision activities based on best available evidence
- Participates in training activities so that supervision is informed by educational theory and practice
- Develops networks to keep up to date with clinical supervision theory and practice
- Engages in research and scholarship to support continuous improvement of clinical supervision practice

DOMAIN 3: ORGANISATION

This domain refers to how a clinical supervisor integrates supervision and opportunities for learning into their clinical practice.

ELEMENT 3.1 INTEGRATION OF SUPERVISION AND LEARNING ACTIVITIES INTO CLINICAL PRACTICE

The Peer Reviewer ascertains that the Reviewee has met the selected descriptors:

SAFE LEARNING ENVIRONMENT

- Identifies learning opportunities within clinical environment that will be instructive for the learner
- Co-ordinates learner participation and determines the level of supervision required for each learning opportunity
- Promotes a learning culture with the organisation that values novice learners in the development of the profession and/or the organisation
- Effectively manages the competing demands of the supervisor- patients, learners and peers
- Negotiates with peers a timetable and space for learners within the organisation
- Guides learners to organise their time and manage their clinical learning opportunities
- Engages with the education provider around the governance, agreements, scope, goals, outcomes of the learning

FOSTERS COMMUNICATION

- Discusses supervisory practice with colleagues to develop a workplace supervisory culture
- Consults with colleagues to discuss any problems and develops strategies to resolve issues in the clinical placement

PROMOTES PROFESSIONALISM

- Models effective team work and explicitly links the learner into the healthcare team
- Promotes active exchange of ideas and redirects questions to other members of the group when appropriate, e.g. Includes other health care providers in patient discussions
- Turns conflict or differences of opinion between team members into learning opportunities
- Helps learners to collectively solve problems or make decisions together

SAMPLE PEER REVIEW TOOLS

The following pages are examples of the PR Tool checklists that could be adopted for the peer review observation session. A blank PR Tool template and three examples are provided:

1. Blank template that could be populated with items selected from the domains, elements and descriptors listed above
2. Peer observation of a clinical supervisor giving feedback to a learner after a clinical encounter
3. Peer observation of a clinical supervisor teaching a clinical skill to a learner
4. Peer observation of a clinical supervisor discussing patient management with a learner

These sample peer review tools have the following characteristics:

- Two sided page- one side for use during the observation and one side to summarise these observations for the post observation discussion
- Categories relevant to the type of learning activity being observed
- Descriptors summarised with key words (rather than the full descriptor). The peer reviewer should refer to the longer list of descriptors if clarification is required.
- Space for the peer reviewer to take notes during their observation that either align to the descriptor or other items that they noted during their observation
- A second page to be used as a summary to provide narrative feedback after the observation. This includes three points for reinforcing comments and three points for constructive comments.

These are available for download from the GNARTN website www.GNARTN.org.au.

PEER REVIEW TOOL SAMPLE

Download template from website: www.gnartn.org.au

_____ - PEER OBSERVATION SESSION	
CLINICAL SUPERVISOR: _____ OBSERVER: _____ DATE:_____	
Descriptor – see full list for further explanation	Notes
Safe Learning Environment	
Fosters Communication	
Promotes Professionalism	
Other	

PEER REVIEW TOOL SAMPLE

Download template from website: www.gnartn.org.au

_____ - POST-OBSERVATION DEBRIEF			
Descriptor -see full list for further explanation	Tick if present	✓	Summary
Safe Learning Environment			Reinforcing comments
Fosters Communication			
			Constructive comments
Promotes Professionalism			
Other			

PROVIDING FEEDBACK TO A LEARNER - PEER OBSERVATION SESSION

CLINICAL SUPERVISOR: _____ OBSERVER: _____ DATE:_____

Descriptor – see full list for further explanation	Notes
Safe Learning Environment • Identifies goals for session • Encourages learner to participate • Stays on task • Manages time	
Fosters Communication • Specific feedback provided • Actively listens • Encourages learner to contribute their opinions • Uses advanced questioning techniques • Checks learner has understood feedback	
Promotes understanding • Explains reasons for opinions • Identifies further strategies for improvement • Concludes session with an agreed plan	
Promotes Professionalism • Shows respect to learner • Models ethical practice	
Other	

PEER REVIEW TOOL SAMPLE

Download template from website: www.gnartn.org.au

PROVIDING FEEDBACK TO A LEARNER - POST-OBSERVATION DEBRIEF			
Descriptor -see full list for further explanation	Tick if present	✓	Summary
Safe Learning Environment	• Identifies goals for session • Encourages learner to participate • Stays on task • Manages time		Reinforcing comments
Fosters Communication	• Specific feedback provided • Actively listens • Encourages learner to contribute their opinions • Uses advanced questioning techniques • Checks learner has understood feedback		
Promotes Understanding	• Explains reasons for opinions • Identifies further strategies for improvement • Concludes session with an agreed plan		Constructive comments
Promotes Professionalism	• Shows respect to learner • Models ethical practice		
Other			

TEACHING A CLINICAL SKILL - PEER OBSERVATION SESSION

CLINICAL SUPERVISOR: _____ OBSERVER: _____ DATE:_____

Descriptor – see full list for further explanation	Notes
Safe Learning Environment • Identifies goals for session • Stays on task • Manages time	
Teaches a skill (using 4 stage model) • Demonstrates the steps • Demonstrates the steps while verbalising key components • Asks learner to repeat key components while performing skills • Asks learner to perform skill while verbalising key components	
Fosters communication • Provides clear instructions • Checks learner has understood steps • Gives feedback about learners performance	
Promotes further learning • Concludes session with an agreed plan • Encourages learner to practice	
Promotes professionalism • Shows respect to learner • Awareness of learner's skills/ abilities	
Other	

PEER REVIEW TOOL SAMPLE

Download template from website: www.gnartn.org.au

TEACHING A CLINICAL SKILL - POST-OBSERVATION DEBRIEF			
Descriptor -see full list for further explanation	Tick if present	✓	Summary
Safe Learning Environment	• Identifies goals for session • Stays on task • Manages time		Reinforcing comments
Teaches a skill (using 4 stage model)	• Demonstrates the steps • Demonstrates the steps while verbalising key components • Asks learner to repeat key components while performing skills • Asks learner to perform skill while verbalising key components		
Fosters communication	• Provides clear instructions • Checks learner has understood steps • Gives feedback about learners performance		Constructive comments
Promotes further learning	• Concludes session with an agreed plan • Encourages learner to practice		
Promotes professionalism	• Shows respect to learner • Awareness of learner's skills/ abilities		
Other			

PATIENT MANAGEMENT DISCUSSION - PEER OBSERVATION SESSION

CLINICAL SUPERVISOR _____ OBSERVER _____ DATE / /

Descriptor – see full list for further explanation	Notes
Safe Learning Environment • Identifies goals for session • Encourages learner to participate • Stays on task • Manages time • Shows interest and enthusiasm	
Fosters communication • Actively listens • Encourages learner to articulate their rationale for ideas • Uses questions to provoke clinical reasoning • Summarises key discussion points	
Promotes understanding & clinical reasoning • Encourages learner to cite rationale for management strategy • Encourages learner to synthesises practice with theory • Directs learner to further research /information • Concludes session with an agreed plan	
Promotes professionalism • Shows respect to learner • Models ethical practice • Shares insights from own experience	
Other	

PEER REVIEW TOOL SAMPLE

Download template from website: www.gnartn.org.au

PATIENT MANAGEMENT DISCUSSION - POST-OBSERVATION DEBRIEF

Descriptor -see full list for further explanation	Tick if present	✓	Summary
Safe Learning Environment	• Identifies goals for session • Encourages learner to participate • Stays on task • Manages time • Shows interest and enthusiasm		Reinforcing comments
Fosters communication	• Demonstrates the steps • Actively listens • Encourages learner to articulate their rationale for ideas • Uses questions to provoke clinical reasoning • Summarises key discussion points		
Promotes understanding & clinical reasoning	• Encourages learner to cite rationale for management strategy • Encourages learner to synthesise practice with theory • Directs learner to further research /information • Concludes session with an agreed plan		Constructive comments
Promotes professionalism	• Shows respect to learner • Models ethical practice • Shares insights from own experience		
Other			

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APPENDIX 1: GLOSSARY

Clinical supervisor: An appropriately qualified and recognised professional who guides learners' education and training during clinical placements. The clinical supervisor's role may encompass educational, support and organisational functions. The clinical supervisor is responsible for ensuring safe, appropriate and high quality patient-client care (HWA, 2014b).

Clinical supervision: This involves the oversight – either direct or indirect – by a clinical supervisor(s) of professional procedures and/or processes performed by a learner or group of learners within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each learner's experience of providing safe, appropriate and high quality patient-client care (HWA, 2014b).

Learner: Includes any individual placed in a clinical setting for the purpose of gaining basic, intermediate or advanced knowledge, skills and attributes under the direct or indirect supervision of a more advanced practitioner (HWA, 2014b).

Peer review: This is a deliberate process by which individuals of the same or different professions, working in similar organisational settings, observe or discuss aspects of their supervisory practices, in order to reinforce areas of strength, and identify areas for further development.

Peer: An individual who is respected by the health professional engaging in peer review, and who collaborates with them to undertake a peer review or peer observation process.

Reviewer or Observer: The individual who is engaging in the observation or review of their peer's clinical supervision practices.

Reviewee: The individual who is having their clinical supervision practices reviewed by a reviewer or observer.

Peer observation of clinical supervision or clinical teaching: The process of a clinical supervisor or clinician watching another colleague's supervision or clinical teaching, without necessarily judging their practice or being required to give feedback (Hendry, Bell & Thompson; 2013).

Peer supervision: This refers to reciprocal arrangements in which peers work together for mutual benefit where developmental feedback is emphasised and self directed learning is encouraged.

APPENDIX 2: METHODOLOGY

The materials presented in these project documents reflect a synthesis of a literature review undertaken from July to August 2014. The search strategy focused on identifying sources addressing workplace-based peer review of a supervisor's approach to providing supervision and included a search of not only the health literature but also peer review undertaken in the education sector. Databases that search both published literature and grey literature were utilised including: MEDLINE, Embase, ERIC, PsycINFO, CINAHL, Scopus, Web of Science, Informit (esp. Health and Education subsets) as well as Google Scholar, Trove and Google search restricted to educational institutions and pdf documents. The key words used were (Peer* OR colleague* OR collegial* OR role model* OR teacher* OR educator* OR coach* OR mentor*) AND (Review* OR audit* OR apprais* OR evaluat* OR guidance OR feedback OR support* OR observation* OR consultation*) AND (Supervis* OR teaching)*, with the set limitations being English language, years 2000 to 2014 inclusive.

The 3610 articles were identified from this search strategy and the first 10 pages of results from the grey literature were cleaned and collated into a citation manager. The authors of this report then rated the most recent 150 articles for relevance to this project and compared their ratings to ensure consistency in their interpretations. The list of articles was then divided between the two authors and a further review was undertaken to identify the most relevant articles and reports from the past 4 years. Once selected, the sources were read in full to provide an evidence-based background to this guide and report. A wiki was used to summarise the key themes and share interpretations such that once saturation of themes had been achieved the project moved onto the resource development stage. Due to the extensive literature and limited time available the whole literature set was not fully reviewed. However sources prior to 2010 that were identified from the key articles were accessed in full and included in the analysis. Hence one limitation of this report is that time constraints did not allow the full literature set to be analysed in detail.

APPENDIX 3: CONTINUUM OF MODELS OF PEER REVIEW

Adapted from Gosling 2014, p 16: As noted in section 2, the collaborative model is the recommended model for this context.

Characteristic	Evaluation model	Developmental model	Collaborative model
Who does it and with whom (peer relationships)	Senior staff or chosen evaluators	Usually observations by more expert staff	Supervisors, peers, colleagues
Purpose	Identify underperformance, appraisal, promotion	Demonstrate competency	Improve supervision through dialogue, self and mutual reflection, stimulate improvement
Outcome	Report / judgement	Feedback, report, action plan for improvement	Analysis, reflection, discussion, wider experience, scholarship activity, improvement to supervision practices
Status of peer review of judgements	Based on authority or expertise or seniority	Expert analysis using their experience	Peer shared understandings and perceptions
Relationship to observer to observed	Hierarchy / seniority	Expert/learner	Equality / mutuality
Confidentiality	Between manager, reviewer and reviewee	Between reviewer and reviewee and possibly manager	Between reviewer and reviewee and could be shared with group of peers
Inclusion	Select staff, staff applying for promotion	Staff who are identified for development	Voluntary, best if all staff involved
Judgement	Pass/fail, score quality assessment	Feedback on how to improve	Non - judgemental, constructive facilitated dialogue
What is reviewed	Any aspect	Any aspect	Any aspect
Who benefits	Institution	Reviewee	Mutual benefits for all (two way)
Conditions for success	Effective management	Respected senior staff	A culture in which supervision is valued and discussed
Risks	Lack of co-operation, resistance	No shared ownership, lack of impact	Confirms existing practice, passive compliance, perceived as bureaucratic

APPENDIX 4:

EFFECT INSTRUMENT: EVALUATION AND FEEDBACK FOR EFFECTIVE CLINICAL TEACHING

The list of domains and observable tasks developed by Fluit et al., (2013) for the Evaluation and Feedback for Effective Clinical Teaching instrument: EFFECT. Note the items starred in italics (*) were removed after validation studies were completed. Reference is also made to the Canadian definition of the competencies needed for medical education and practice known as CanMEDS.

1. **Domain: Role modelling**
   Role modelling clinical skills
   1. Perform history taking
   2. Examine a patient
   3. Perform clinical skills and procedures

   Role modelling scholarship
   4. Apply academic research results

   Role modelling general CanMEDS roles
   5. Cooperate with other health professionals while providing care to patients and relatives
   6. Communicate with patients
   7. Cooperate with colleagues
   8. Organize my own work
   9. Apply guidelines and protocols
   10. Treat patients respectfully
   11. Handle complaints and incidents
   12. Bring bad news

   Role modelling professionalism
   13. Indicates when he/she does not know something
   14. Reflects on his/her own actions
   15. Is a leading example of how I want to perform as a specialist

2. **Domain: Task allocation**
   16. Gives me enough freedom to perform tasks suiting my current knowledge/skills on my own
   17. Gives me tasks that suit my current level of training
   18. Stimulates me to take responsibility
   19. Gives me the opportunity to discuss mistakes and incidents
   20. Seizes many opportunities to teach me something*
   21. Teaches me how to organize and plan my work
   22. Prevents me from having to perform too many tasks irrelevant to my learning
   23. Makes me enthusiastic about the specialism I am studying*

3. **Domain: Planning**
   24. Reserves time to supervise/counsel me
   25. Sticks to training appointments made with me*
   26. Is available when I need him/her during my shift
   27. Sets aside time when I need him/her

4. **Domain: Feedback**
   Quality of the feedback
   28. Bases feedback on concrete observations of me
   29. Indicates what I am doing correctly
   30. Discusses what I can improve
   31. Lets me think about strengths and weaknesses
   32. Reminds me of previously given feedback

33. Formulates feedback in a way that is not condescending or insulting

Content of the feedback

34. My clinical and technical skills
35. How I communicate with patients
36. How I work together with my colleagues
37. How I apply evidence-based medicine in my daily work
38. How I make ethical considerations explicit
39. How I guard the limits of my expertise

5. Domain: Teaching methodology

40. Reviews the learning objectives
41. Asks me to explain my choice for a particular approach (diagnosis, therapy)
42. Discusses the possible clinical courses and/or complications
43. Reviews my reports
44. Stimulates me to find out things for myself
45. Stimulates me to ask questions
46. Makes me do oral presentations on a regular basis*
47. Stimulates me to actively participate in discussions
48. Explains complex medical issues clearly

6. Domain: Assessment

49. Prepares progress reviews
50. Stimulates me to prepare for such reviews *
51. Makes a clear link with previously set learning objectives during these reviews
52. Gives me the opportunity to raise issues of my own
53. Formulates next-term learning objectives during these reviews with me
54. Gives a clear and exhaustive assessment
55. Explains how he/she used my portfolio for the assessment *
56. Explains how staff was involved in the assessment
57. Reviews my portfolio during the assessment
58. Pays attention to my self-direction

7. Domain: Personal support

59. Treats me respectfully
60. Is an enthusiastic instructor/supervisor
61. Lets me know I can count on him/her
62. Supports me in difficult situations (e.g. morning report)
63. Doesn't make any unfavourable differentiations based on gender, culture or ethnicity*
64. Is open to personal questions/problems
65. Helps and advises me on how to maintain a good work-home balance

APPENDIX 5:
PLANNING FOR THE PEER REVIEW – "WH" QUESTIONS

Åkerlind & Pettigrove (1996, piii) suggested using eight "wh" questions to guide planning. They are reproduced in full here. The full document is available at
http://chelt.anu.edu.au/sites/default/files/toolkitv2_peer_self.pdf

Who is communicating

To Whom,
How,
When,
Where,
Why,
To What Effect -

and in the light of all this, **What** meaning does the communication ultimately have for you?

Unpacked, this question suggests that your choice of peer review strategies will be more appropriate, and your interpretation of the information that comes to hand will be better if you know

... **who** stands behind the statements you're paying attention to - e.g. what their linguistic, cultural and educational backgrounds are; whether their expectations or experience of university teaching and learning are like or unlike yours; how aware or well-informed they are about their own practices and their own progress as teachers etc.,

... **to whom** they think they are giving their information - e.g. to you direct; to somebody else through you; to you as a less experienced colleague; to you as an equal; to you as a better informed or better placed colleague; or not to you at all, but to some other specific or generalised audience; whether they believe there is a relationship of trust, or a mutually beneficial arrangement of some kind, or no relationship at all between them and you or their other intended audience

... **how** they communicate - i.e. what form(s), manner(s) or style(s) of delivery they've used on this occasion, compared with those they are given to using elsewhere; how formal or informal, studied or spontaneous, distilled and structured or elaborative and exploratory their communications are

... **when** the communication was composed, transmitted and received; what temporal considerations (amount of time taken, allowed or required; time of day; time of year etc.) influenced the composition, transmission and reception; how much time elapsed between the request for information and the response; how much time the communicator believes will elapse before you get back to them

... **where** the communication was composed, transmitted and received; what considerations of space or place (confined, comfortable, appropriate, inappropriate, familiar, not familiar) influenced the composition, transmission and reception

... **why** the communication is as it is - e.g. whether the information is shaped by established knowledge or by the pressure of circumstances or the rush of a conversation; whether it's motivated by anger, a passionate commitment, a desire to persuade, a willingness to share in an exploration and a discovery, or a need to have the communication over and done with as quickly as possible; whether it's being offered in the expectation of a reward or a response, in the hope that it will be acted on quickly, in the knowledge that it will be discussed thoroughly and acted on slowly, or in the belief that it may never be discussed or acted on at all

... **what** effect the communication has on you as you receive it, and subsequently, after reflection - i.e. whether it confirms or challenges your previously established understandings, or causes you to develop, clarify, strengthen or abandon them; what effect the communication has on others ... in the light of all this, precisely what can the communication add to your understanding of the thing you are reviewing, what new steps does it enable you to take, what strength does it add to your stand-point?

APPENDIX 6:
PRINCIPLES OF QUALITY FEEDBACK

This section is from Harris K, Farrell K, Bell M, Devlin M James R. (2008). Peer Review of Teaching in Australian Higher Education p75 available from
http://www.cshe.unimelb.edu.au/research/teaching/docs/PeerReviewHandbook_eVersion.pdf

Support for the original work was provided by the Australian Learning and Teaching Council Ltd, an initiative of the Australian Government Department of Education, Employment and Workplace Relations.

Advice on giving, receiving and using feedback

Feedback and peer review of teaching

The term 'feedback' is often used in coaching and management literature to refer to the process of a practitioner or manager providing information on performance to a client or employee, respectively and the feedback often focusses on skills practice. Peer review of teaching recognises the complex and subjective nature of educational interaction, thus feedback is of a more personal form, going beyond behavioural change to the human interactions at the heart of teaching. Offering and receiving feedback can, therefore, be quite challenging as both involve highly developed interpersonal skills. Giving feedback on teaching means describing what the peer reviewer sees, hears and senses happening in the teaching situation or in the curriculum or other documentation, as well as how that fits with what the reviewer understands about teaching and learning. For example, it may mean communicating how the reviewer feels about the teaching climate (comfortable, threatening, challenging) as this can provide significant input into discussions about the learning environment being set up by the reviewee.

The nature of effective feedback

Central to effective feedback is a focus on the reviewee's professional development. Feedback should be useful to the reviewee in developing strategies for change to their teaching, where needed. This is most effectively achieved through the reviewer acting as a 'critical friend', as distinguished from being critical of the reviewee's teaching. The notion of a critical friend assumes a level of honesty within a supportive relationship. Research in this area aligns with common sense and indicates that feedback is more effective when the reviewer is respectful, supportive and empathetic.

Feedback should also be as specific as possible, indicating what was observed as well as judgements about what was observed.

Feedback is more likely to be effective if it is manageable. If a reviewee is forced to confront a large number of major issues at one time, they may feel overwhelmed. A general rule of thumb is that a feedback session should provide supportive feedback and address two to three main areas where there may be need for development.

Principles of good practice in providing feedback

There is broad consensus in the writing on peer review of teaching that feedback is optimised when:

- Feedback is descriptive and evidence-based. Feedback means literally "feeding back" to the teacher what the peer has observed (seen, heard, read) with examples of these observations.
- The spirit of feedback is developmental. Regardless of the major reason for peer review, the purpose of feedback is to assist the improvement of teaching.
- Feedback is focussed on the goals and objectives set by the reviewee and explained/

discussed with the reviewer. Feedback on other areas is given if the reviewer considers such feedback useful.

- Verbal feedback is supported by written feedback. Written feedback provides substantial information for reflection before and/or after the verbal feedback session(s).
- Feedback is appropriate to the skill level of the teacher. Early career academics might find feedback on technical skills useful. Experienced academics can find feedback useful if it challenges them to articulate the reasons behind their effective practice.
- Feedback is timely. Feedback is more effective when it is given as soon as possible after the review.
- The setting for feedback discussion is neutral, where neither reviewee nor reviewer feels intimidated by the surroundings and where confidentiality is assured.

Feedback tips for reviewers

Give particular emphasis to what the reviewee wants to achieve.

Ask open questions during verbal feedback.

Choose words carefully. In particular, note that appending a positive comment with "but ..." is likely to negate the positive feedback. When seeking to provide affirmation, avoid adding qualifying comments, and instead deal with these separately.

Seek ways to affirm the reviewee's work, identifying what works well and why.

Feedback tips for reviewees

It is important to listen carefully to verbal feedback. Interrupting to rebut comments during verbal feedback should be avoided as it distracts from listening and considering the comments.

Active listening means fully engaging with the communication, and includes seeking clarification of what the reviewer means, as necessary. For example: "You said some of the points could have been clearer. Can you give me an example?" or "I'm glad you think it was effective. Was there anything specific you thought was effective

APPENDIX 7:
EDUCATIONAL RESOURCE FOR CLINICAL SUPERVISORS

ONLINE RESOURCES

1.Introduction to Clinical Supervision eLearning Packages: a set of 3 free self-paced modules that were created by an Northern Territory Regional Training Network (NTRTN) project in 2013-2014:

Module 1: Introduction to clinical supervision - where supervision is defined and described, role of the supervisor discussed and benefits and disadvantages of supervision outlined.
Module 2: Teaching and Learning in the workplace - which describes the attributes of effective teaching, adult learning principles and the difference between learning in the classroom and workplace.
Module 3: Developing professional expertise - which describes the continuum of supervision from dependent to peer consultative relationship, outlines the development of expertise, describes the stages of awareness and four levels of knowledge and finally defines clinical reasoning and critical thinking.

Available from the Northern Territory Department of Health My Learning website:
http://mylearninghealth.nt.gov.au/login/index.php
(if you have an NT epass you can access these, if not you can request free access from this page too)

2. On Track eLearning Package: In 2013 the WACHS Allied Health Clinical Education Program undertook the development of an interprofessional eLearning package with funding made available by Health Workforce Australia.. Designed for rural and remote allied health and nursing professionals the package covers everything from planning, commencing, carrying out and evaluating student placements. The package can be accessed here
http://www.health.wa.gov.au/wactn/home/wachs_resources.cfm

Module 1: Deciding to start – planning and preparing for student placement
Module 2: Starting your journey – commencing placement and orientation
Module 3: On the road of supervision – conducting a supervision session and evaluating students
Module 4: Looking back at the journey – facilitating reflection and evaluation of the supervisory experience
Module 5: Skills 1 for your journey – coaching and communication skills
Module 6: Skills 2 for your journey – teaching skills, emotional intelligence, conflict resolution, professional skills and managerial skills
Module 7: Journey to self-discovery – understanding how communication and learning styles, culture and experience influence supervision
Module 8: Navigating your way to more effective supervision – developing a plan to advance your supervision skills
Module 9: Bumps in the road – managing difficulties in student performance and the supervisory relationship
Module 10: Working with and providing supervision to others – identifying legislated and ethical supervisory obligations, and utilising supervision skills in multifaceted roles.

3. Clinical Supervision Support Across Contexts: a series of online modules for a range of health professions created by HWA and Department of Health Victoria – free to register for account http://clinicalsupervisionsupport.org/

There is a core module covering roles and responsibilities of clinical supervisors, identifying your strengths and learning needs, understanding how students learn, ways of facilitating student learning, key components of feedback and clinical assessment and how to recognise underperforming students and use effective management strategies.
There are also profession specific modules for the following professions: audiology, dentistry, general practice, medical education, medical radiation sciences, midwifery, nursing, nutrition & dietetics, occupational therapy, paramedics, pharmacy, physiotherapy, podiatry, psychology, social work.

Finally there are also domains of practice modules: aged care, disability, drugs and alcohol, emergency medicine, homelessness services, paediatrics, international health professionals, mental health and rehabilitation.

4. Workplace-based assessment online: A resource developed by the Australian Medical Council to assist supervisors in assessing clinical skills and knowledge in the workplace. Although it is aligned to using tools from the Australian Medical Council it has resources and videos that could be utilised for any profession, such as the feedback resources. It is available from this webpage: http://wbaonline.amc.org.au/ and it has four sections:

Cased based discussion
Multisource feedback
Resource guide with several sections outlining assessment principles and tools
Giving effective feedback

OTHER RESOURCES

1. NT Department of Health Library Services: Clinical supervision subject guide
http://elibrarygroups.health.nt.gov.au/clinicalsupervision

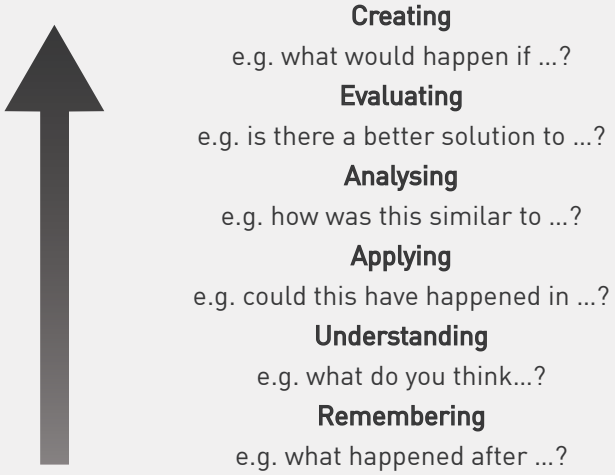
APPENDIX 8: ADVANCED QUESTIONING TECHNIQUES

This extract is from the New South Wales Education and Training Institute (HETI) Hospital Skills Program 2012 Guide: Learning and Supervising: A guide for participants and supervisors in the professional development process pilot (page 27) available from http://www.heti.nsw.gov.au/Global/HETI-Resources/HSP/learning%20and%20supervision%20a%20guide%20for%20in%20the%20professional%20development%20process%20pilot%20hsp%202012.pdf

Advanced questioning involves the skill of asking high order questions to provide opportunities for learners to respond in increasingly thoughtful ways, stimulating different levels of cognitive demand. You need to ask – what type of thinking do you want the question to generate? Whatever the learning setting is, the questions used should help develop the cognitive skills of reasoning and critique.

BLOOM'S TAXONOMY

Bloom's Taxonomy is a classification of thinking (Bloom, et al., 1956[3]) and in its revised state (Anderson & Sosniak, 1994[4]), describes six levels of cognitive tasks from the most basic to higher order of thinking skills. These are shown in the diagram below:



All learning needs to include the cognitive tasks of remembering, understanding and applying, however to promote deep learning and enhance clinical reasoning, the aim should also be to use questions that promote analysing, evaluating and creating. This is particularly important when setting learning objectives to ensure the learner achieves the level of thinking and reasoning required.

A comprehensive table of questions to develop each category of thinking and verbs to set learning objectives (Bloom's Taxonomy) is below.

[3] Bloom, B. S.; Engelhart, M. D.; Furst, E. J.; Hill, W. H.; Krathwohl, D. R. (1956). Taxonomy of educational objectives: The classification of educational goals. Handbook I: Cognitive domain. New York: David McKay Company.

[4] Anderson, L. W., & Sosniak, L. A. (Eds.). (1994). Bloom's taxonomy: A forty-year perspective. Ninety-third Yearbook of the National Society for the Study of Education. Chicago: University of Chicago Press.

Cognitive levels of thinking	Useful verbs to use when setting learning objectives	Sample questions that promote thinking at these levels
Remembering	Tell List Describe Relate Locate Write Find State Name	What happened after...? How many...? Who was it that...? Can you name the...? Describe what happened at ...? Who spoke to ...? Can you tell why ...? Find the meaning of...? What is...? Which is true or false...?
Understanding	Explain Interpret Outline Discuss Distinguish Restate Translate Compare Describe	Can you write in your own words...? Can you write a brief outline...? What do you think could have happened next...? Who do you think...? What was the main idea...? Who was the key person...? What differences exist between...? Can you provide an example of what you mean...? Can you provide a definition for...?
Applying	Solve Show Use Illustrate Construct Complete Examine Classify	Do you know another instance where...? Could this have happened in...? Can you group by characteristics such as...? What factors would you change if...? Can you apply the method used to some experience of your own...? What questions would you ask of...? From the information given, can you develop a set of instructions about...? Would this information be useful if you had a...?

PROBING QUESTIONS

Probing questions are used to help learners think through their responses more thoroughly. You might use probing questions to gain clarification or encourage an expanded explanation.

Examples of probing questions

- Can you be more specific?
- What makes you think that?
- How might other people see this?
- In what ways is that relevant?
- What is an example of that?
- How reliable is the evidence?
- What is the underlying principle?

Adapted from (Van Ments, 1990, p. 80[5])

[5] Van Ments, Morry (1990). Active talk: the effective use of discussion in learning. Kogan Page ; New York : St. Martin's Press, London

USING QUESTIONS TO MODEL THINKING SKILLS

The ability to 'think about your thinking' is called metacognition (Barrows, 1992). Metacognition is an essential part of clinical reasoning which the facilitator can model (demonstrate or promote) by asking the learner to think or reason through a problem or situation.

Example questions to model thinking skills

- What is going on in this problem or situation? Do you have the entire picture?
- Have you experienced this situation in the past?
- Do you know enough about this problem or situation to handle it?
- Have you thought about the possibilities?
- What information do you need to consider these possibilities?
- What does this finding mean?
- What is the best way to manage this?
- What is the supporting evidence for this idea

APPENDIX 9:
KEY JOURNAL ARTICLES DESCRIBING PEER REVIEW OF CLINICAL SUPERVISION

The following journal articles were selected as providing helpful further reading for this area. The abstract is included as well as any further comments to assist in your review of these literature sources. It is not possible to provide these articles in full text as this would breach the copyright rules, however you should be able to source the full text through your local departmental or university library.

Siddiqui, Z. S., Jonas-Dwyer, D., & Carr, S. E. (2007). Twelve tips for peer observation of teaching. Medical Teacher, 29(4), 297-300.

This paper outlines twelve tips for undertaking peer observation of teaching in medical education, using the peer review model and the experiences of the authors. An accurate understanding of teaching effectiveness is required by individuals, medical schools, and universities to evaluate the learning environment and to substantiate academic and institutional performance. Peer Observation of Teaching is one tool that provides rich, qualitative evidence for teachers, quite different from closed-ended student evaluations. When Peer Observation of Teaching is incorporated into university practice and culture, and is conducted in a mutually respectful and supportive way, it has the potential to facilitate reflective change and growth for teachers.

Comments on this paper: *The models of peer observation of teaching are outlined (evaluation, development and peer review) and then 12 tips are described. They are:*

1. *Choose the observer carefully*
2. *Set aside time for the peer observation*
3. *Clarify expectations*
4. *Familiarise yourself with the course*
5. *Select the instrument wisely*
6. *Include students*
7. *Be objective*
8. *Resist the urge to compare with your own teaching style*
9. *Do not intervene*
10. *Follow the general principles of feedback*
11. *Maintain confidentiality*
12. *Make it a learning experience*

Finn, K., Chiappa, V., Puig, A., & Hunt, D. P. (2011). How to become a better clinical teacher: a collaborative peer observation process. Medical Teacher, 33(2), 151-155.

BACKGROUND: Peer observation of teaching (PoT) is most commonly done as a way of evaluating educators in lecture or small group teaching. Teaching in the clinical environment is a complex and hectic endeavour that requires nimble and innovative teaching on a daily basis. Most junior faculty start their careers with little formal training in education and with limited opportunity to be observed or to observe more experienced faculty.

AIM: Formal PoT would potentially ameliorate these challenges.

METHODS: This article describes a collaborative peer observation process that a group of 11 clinician educators is using as a longitudinal faculty development program.

RESULTS: The process described in this article provides detailed and specific teaching feedback for the observed teaching attending while prompting the observing faculty to reflect on their own teaching style and to borrow effective teaching techniques from the observation.

CONCLUSION: This article provides detailed examples from written feedback obtained during collaborative peer observation to emphasize the richness of this combined experience.

Comments on this paper: *This paper outlines the advantage of using a collaborative approach to peer review rather than an evaluative one (see appendix 3). They also highlight the importance of the reviewer making detailed notes about the observed session to not only to guide the feedback to the reviewee but also to prompt the reviewer to engage in self-reflection about their own supervision practice. The authors analysed the recorded notes collected by the reviewees during observations and noted that the areas that were the most difficult were questioning techniques, timing and appropriateness of questions. They also found that if reviewees learnt a lot from the reviewer reflecting back the actual questions they had asked in their observed session during the post observation feedback, and reviewers appreciated watching others ask questions in real time.*

Gusic, M., Hageman, H., & Zenni, E. (2013). Peer review: a tool to enhance clinical teaching. The clinical teacher, 10(5), 287-290

BACKGROUND: The system used by academic health centres to evaluate teaching must be valued by the large number of faculty staff that teach in clinical settings. Peer review can be used to evaluate and enhance clinical teaching. The objective of this study was to determine the perceptions of clinical faculty about the effects of participating in peer review.

METHODS: Faculty members were observed teaching in a clinical setting by trained peer observers. Feedback was provided using a checklist of behaviours and descriptive comments. Afterwards, semi-structured interviews were conducted to assess the faculty member's perception about the process. Notes from the interviews were analysed using a grounded theory approach. The study was approved by the institutional review boards of all the institutions involved.

RESULTS: Three themes emerged from the interviews with faculty members: (1) they found the process to be valuable - they received information that affirmed "good" teaching behaviours, and were prompted to be more focused on their teaching; (2) they were motivated to enhance their teaching by being more deliberate, interactive and learner-centred; and (3) they were inspired to explore other opportunities to improve their teaching skills.

DISCUSSION: Peer review is a process that promotes the open discussion and exchange of ideas. This conversation advances clinical teaching skills and allows high-quality teaching behaviours to be strengthened.

Comments on this paper: *This paper highlights the advantages of the peer review process for both the reviewee and the reviewer. It also enabled participants to identify areas they could develop to enhance their supervision and teaching. Interestingly they noted that the most frequently observed behaviours were "listens to learners, maintains rapport with patients, reveals a broad knowledge base, and how relationships between theory and practice and shows respect for learners and patients". The less frequently observed behaviours included provides constructive feedback to learners, encourages exchanges between learners and patients, elicits feedback on his or her clinical performance from the learner and shares the legal boundaries of the profession with learners." (p 288).*

Fluit, C., Bolhuis, S., Grol, R., Ham, M., Feskens, R., Laan, R., & Wensing, M. (2012). Evaluation and feedback for effective clinical teaching in postgraduate medical education: Validation of an assessment instrument incorporating the CanMEDS roles. Medical Teacher, 34(11), 893-901

BACKGROUND: Providing clinical teachers in postgraduate medical education with feedback about their teaching skills is a powerful tool to improve clinical teaching. A systematic review showed that available instruments do not comprehensively cover all domains of clinical teaching. We developed and empirically test a comprehensive instrument for assessing clinical teachers in the setting of workplace learning and linked to the CanMEDS roles.

METHODS: In a Delphi study, the content validity of a preliminary instrument with 88 items was studied, leading to the construction of the EFFECT (evaluation and feedback for effective clinical teaching) instrument. The response process was explored in a pilot test and focus group research with 18 residents of 6 different disciplines. A confirmatory factor analyses (CFA) and reliability analyses were performed on 407 evaluations of 117 supervisors, collected in 3 medical disciplines (paediatrics, pulmonary diseases and surgery) of 6 departments in 4 different hospitals.

RESULTS: CFA yielded an 11 factor model with a good to excellent fit and internal consistencies ranged from 0.740 to 0.940 per domain; 7 items could be deleted.

CONCLUSION: The model of workplace learning showed to be a useful framework for developing EFFECT, which incorporates the CanMEDS competencies and proved to be valid and reliable.

Comments on this paper: *This paper describes the validation of the EFFECT instrument which we have included in appendix 4 and used to inform the development of the Peer Review Tool for this project. The main difference is that the EFFECT tool is designed to be used by resident doctors (learners) evaluating their supervisors rather than by peers. The main value of this paper is the range of domains identified and the complexity of clinical supervision practice.*

Mookherjee, S., Monash, B., Wentworth, K. L., & Sharpe, B. A. (2014). Faculty development for hospitalists: structured peer observation of teaching. Journal of Hospital Medicine (Online), 9(4), 244-250.

BACKGROUND: Hospitalists provide much of the clinical teaching in internal medicine, yet formative feedback to improve their teaching is rare.

METHODS: We developed a peer observation, assessment, and feedback program to improve attending hospitalist teaching. Participants were trained to identify 10 optimal teaching behaviours using a structured observation tool that was developed from the validated Stanford Faculty Development Program clinical teaching framework. Participants joined year-long feedback dyads and engaged in peer observation and feedback on teaching. Pre- and post-program surveys assessed confidence in teaching, performance of teaching behaviours, confidence in giving and receiving feedback, attitudes toward peer observation, and overall satisfaction with the program.

RESULTS: Twenty-two attending hospitalists participated, averaging 2.2 years (+ 2.1 years standard deviation [SD]) experience; 15 (68%) completed pre- and post-program surveys. Confidence in giving feedback, receiving feedback, and teaching efficacy increased (1=strongly disagree, 5=strongly agree, mean+SD): "I can accurately assess my colleagues' teaching skills," (pre=3.2+0.9 vs post=4.1+0.6, P<0.01), "I can give accurate feedback to my colleagues" (pre=3.4+0.6 vs post=4.2+0.6, P<0.01), and "I am confident in my ability to teach students and residents" (pre=3.2+0.9 vs post=3.7+0.8, P=0.026).

CONCLUSIONS: Peer observation and feedback of teaching increases hospitalist confidence in several domains that are essential for optimizing teaching. Further studies are needed to examine if educational outcomes are improved by this program.

Comment on this paper: *Interestingly participants in this study were provided with an incentive to participate (small monetary reward for completing the observations). The authors suggested encouraging observations as a part of day to day supervisory / teaching practices rather than formally identifying pairs to undertake peer review. They suggested that this would help to embed the practice in the clinical environment. The Peer Review Tool checklists developed for this project are modelled on those used in this research.*

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ISBN: 978-0-9942199-0-9