

Victorian Healthcare Association

Community Health and Small Rural Clinical Placement Development Program



Project Review

June 2011

**This project is an initiative of
the Department of Health**





Executive Summary

The Community Health and Small Rural Clinical Placement Development Program (CH&SRCPDP) aims to support effective clinical placements within community health and small rural health services. The Victorian Healthcare Association (VHA) is contracted by the Department of Health (DH) to manage and **implement this initiative over a 12 month period.**

One of the program activities is to undertake a review of current and past clinical placement projects. The scope of this review includes analysis of existing projects and practical examples primarily from Victoria in relation to student clinical placements.

Specifically, the project review describes the barriers to increasing placement capacity in the sector and suggests methods for overcoming these barriers. It examines best practice approaches to improving the capacity for, and quality of, placements in the sectors.

Key strategies identified in the review to enable increased capacity and quality of placements in the sector can be summarised as follows:

- Centralising placement coordination within agencies and including placements in annual planning cycles
- Streamlining application and orientation processes for students
- Promoting the value of placements in the sector to staff and students
- Providing clarity around placement expectations for students
- Providing supervision training and support to staff
- Including placement supervision in all relevant position descriptions
- Providing increased organisational support to students undertaking placements (such as accommodation, transport, IT, physical space within agencies)
- Investigating innovative placements (such as multidisciplinary, multi-student or multi-site placements)

This review provides examples of the way many of these strategies have been tested in agencies in Victoria, interstate and internationally and shown to be effective in improving placement capacity and/or quality. The challenge is to replicate successful strategies across organisations and sectors. Many of these strategies could be implemented within organisational structures; however some of these strategies may require additional resourcing and support to make broad implementation achievable.



Project Review

Community Health and Small Rural Clinical Placement Development Program

1. Introduction

Clinical placements are an important aspect of healthcare education in Victoria. Clinical experience enables students to integrate and apply the knowledge, skills and attitudes they learn in the classroom in clinical settings, equipping them for the work they will undertake as qualified practitioners.

The Department of Health (DH) has developed a clinical placements strategy to support a more cohesive and sustainable approach to clinical education in Victoria. The strategy, *Clinical Placements in Victoria: Establishing a Statewide Approach* identifies key objectives and priorities across five broad areas: governance and coordination, funding, innovation, data and planning, and enhanced capacity and quality.¹

This strategy was the foundation for the establishment of new network arrangements for clinical placement coordination in Victoria. The new arrangements include 11 geographically-defined Clinical Placement Networks (CPNs) and a statewide advisory body, the Victorian Clinical Placements Council. The CPNs will assist in developing and implementing locally-driven approaches to clinical placement planning, coordination and delivery that reflect the needs of stakeholders in the region.

The Community Health and Small Rural Clinical Placement Development Program (CH&SRCPDP) is part of the broader clinical placement strategy to promote clinical placement activity in non-acute health settings and enhance capacity and quality in these sectors. Community Health and Small Rural Health Services have traditionally been less involved in hosting student clinical placements. Increasing student participation in these sectors will provide a broader, better-rounded learning experience to medical, nursing and allied health students.

The Victorian Healthcare Association (VHA) is contracted by the DH to manage and implement this initiative over a 12-month period. The project is being undertaken in parallel with two other DH-funded projects, focusing on supporting the capacity for and quality of, clinical placements in the residential aged care and community-based mental health sectors.

The CH&SRCPDP aims to support effective clinical placements within community health and small rural health services. It will contribute to the capacity of organisations to facilitate a greater uptake of existing resources, troubleshoot local road blocks to placements, share best practice examples and assist with the implementation of systemic processes.

The long-term objective of the program is to increase clinical placement capacity in Victorian community health and small rural health services, through developing appropriate organisational systems to sustain high quality clinical experiences for the next generation of health workers.

It has been identified that additional capacity building activities are required to increase the number and quality of student placements within these settings. This project review will analyse existing information and projects to describe the barriers to increasing placement capacity and identify strategies currently used by the sectors to improve the capacity for and quality of clinical placements.



An adjunct to the project review is five case studies showcasing innovative student placement strategies being undertaken by community health and small rural health services in Victoria.

2. Methodology and Scope of the Project Review

The project review has drawn on existing projects and practical examples, primarily in Victoria. A full literature review of academic databases was not undertaken for several reasons. Firstly, a brief search of academic literature on clinical placements in small rural health services and community health services - both in Australia and overseas - revealed that the literature almost exclusively examines the effectiveness of clinical placements as a recruitment strategy for services. Using placements as a recruitment strategy is not the focus of this review or the CH&SRCPDP project. Recruitment is an outcome of improving placement capacity and quality, thus this literature was not relevant.

Secondly, a number of projects have been undertaken in Victoria in recent years looking at clinical placements, primarily in the community health sector. The work of these projects has focused on the placements themselves, more than the employment outcomes. This work has been valuable and it was viewed as important that this work be examined holistically and the findings drawn together.

The findings from the projects identified below have been used to inform this research:

- The Community Health Services Teaching and Research Project was conducted by the Australian Institute for Primary Care at La Trobe University in 2005. The project was funded by the Department of Human Services to provide options for establishing a model for 'Teaching Community Health Services'
- The Upper Hume Community Health Service Student Placement Project (Upper Hume Project) was conducted during 2007 and examined the barriers to placements in the community health sector in the Upper Hume region of Victoria and provided a suggested model for coordination of placements in the future
- The former North West Metropolitan Student Placement Project (NWMR Project), conducted from 2008 to November 2010, has been looking at placements in the community health sector in Victoria
- CRESCENT is a current project being run by the University of Melbourne and is broadening placement settings in the north-west Metropolitan region

Further research also revealed a number of other relevant projects and reviews undertaken interstate and overseas. These projects are primarily practical examples of strategies that have been used to increase the number and quality of clinical placements in small rural health services (grey literature) rather than academic studies.

There has been little work done in Victoria specifically on increasing placement numbers and quality in small rural health services. The Upper Hume CHS Project was based in a rural area and is thus relevant to small rural health services. In general, other research undertaken on student placements in rural areas has primarily focused on the effectiveness of placements as a recruitment strategy for graduates. However, a small sample of the more relevant examples of this type of literature has been examined in order to bring an understanding of the issues in this sector. In addition, a small selection of best practice projects operating in small rural health services interstate and overseas has been included, particularly the British Columbia Rural Academic Health Project. Findings from the Upper Hume Project have also been utilised.

The Commonwealth Department of Health and Ageing (DoHA) funded University Departments of Rural Health (UDRH) program has also been included, as this program has vastly increased



placements in a number of disciplines in rural areas where a UDRH exists. In addition, some examples of distinct programs operating at individual UDRHs have been included to highlight the issues faced by the sector as well as present methods of overcoming them.

The Rural Clinical Schools program (RCS) - also funded by DoHA and closely related to the UDRH program - has not been closely examined in this study. The RCS program is aimed at medical students and provides long-term placements, generally of a year's duration. Placements of this duration do not occur in any other discipline. The RCS program is intended to ensure that 25 per cent of medical students spend a year on a rural placement during their degree. Many RCSs also provide short term rotations in small rural health services as part of the placement, which is generally based at a larger regional facility.²

3. Findings

A number of projects have examined the barriers to increasing the capacity for, and quality of, student placements in the community health sector and to a lesser extent in small rural health services. Perceptions of these barriers have been sought from clinicians and other health service workers, students and staff of educational institutions. Many of these projects have also considered strategies to enable student placement capacity and quality to be increased in the sectors. This review draws on a variety of surveys and studies on student clinical placements from a broad range of sectors. Despite the variety, some common clear themes have emerged that relate to both the community health services and small rural health services, and these are examined below.

The findings of this project are presented in four sections:

- **Agencies** - examines the ways organisations can address barriers to increasing the numbers of student placements hosted and the quality of such placements
- **Students** - explores the methods by which student reluctance to participate in placements in community health and small rural health services can be overcome
- **Educational Institutions** - provides information about the strategies education providers placing students can use to support agencies and students in order to increase placement capacity and quality
- **Coordination** - outlines ways coordination processes between education providers and services can be improved

3.1 Agencies

The projects examined identified a number of issues agencies can address in order to increase placement capacity and/or quality. These fall broadly under the areas of infrastructure, policies and processes, orientation procedures, accommodation and transport support for students and staff ability, capacity and willingness to supervise.

The NWMR Project Student Placement Activity Report examined the following barriers to increasing placement capacity in the participating community health services:

- *"A lack of staff in Community Health who have received training to supervise students on placement"*
- *A lack of staff in Community Health who have supervision of students included as a responsibility in their position description (the exception was supervisory staff)*
- *Student Placement Policies of mixed quality with a number not being comprehensive and some organisations with incomplete policies and/or policies which could not be located*



- *A lack of physical space to accommodate students*
- *An inability to count hours spent with students for reporting purposes which made meeting targets difficult*
- *Organisational cultures where student supervision was not considered a key role of the agency and may be considered disruptive to normal work practice*
- *A lack of coordination in the setting up of student placements”³*

Student Placement Policies from 11 community health services were reviewed as part of the research for that report. The report noted that “Student Placement Policies [were] of mixed quality with a number not being comprehensive and some organisations with incomplete policies and/or policies which could not be located.”⁴ The report also stated that “...only a minority of organisations have any sort of register or central record for documenting students who have undertaken placements.”⁵

The lack of infrastructure available at health services has been identified by several studies as a significant barrier to increasing placement capacity. Specifically, a lack of physical space and facilities to accommodate students has been identified in three separate surveys as major impediments to the ability of both health services and students to provide or undertake placements.⁶

The community health service chief executives interviewed as part of the La Trobe University Community Health Services Teaching and Research Project saw the funding constraints inherent in operating their services as one of the primary barriers to increasing placement capacity. It was also noted that they felt funding arrangements did not encourage increasing placements.⁷ Whilst these issues still remain, there have been some changes to the DH funding guidelines.

“Where a student who is supervised by a professional performs a Direct Care or Direct Care – indirect service, the professional can record the direct or indirect service time but the student time cannot be counted.”⁸

One of the most important issues for agencies to address is facilitating cultural change to view placements as part of the core business of the organisation.

The NWMR Project identified this cultural shift as an important process and much of its work has had that change as an underlying aim. Many of the strategies mentioned elsewhere in this report also relate to effecting this shift in organisational culture to view student placements as central to the work of agencies.

Some strategies to effect this shift have also been suggested, for example the inclusion of placement reporting in reports to Boards and in annual reporting.⁹

The Upper Hume Project suggested that recognition of community health services as teaching organisations by the Department of Health was necessary if placements were to be recognised by the organisations as core business.¹⁰ Such recognition would have two effects – firstly that teaching is core to the activities of the organisation and secondly that it is funded to allow more budgetary manoeuvrability for organisations.

The NWMR Project also found that establishing standard methods of counting placement activity for reporting purposes would increase the capacity for staff to supervise placements: “The time taken to supervise students must be accounted for by staff to enable any significant



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increase in capacity. This is because placement activity will be constantly competing with the need for staff to see clients in order to meet targets.”¹¹

The NWMR Project also outlined the following strategies for organisations to “promote a workplace that is supportive of students”:

- a) *“Determine and make clear to all staff that learning is part of the organisation's strategy*
- b) *Clarify that placements are an opportunity to learn, rather than a requirement to teach*
- c) *Plan for students*
- d) *Place students on the clinical roster*
- e) *Provide a dedicated desk and computer for students*
- f) *Allow students to access the organisation's fleet of cars*
- g) *A report on student placements is included in the community health services board report”*¹²

Innovative forms of placement have also been identified as methods by which services can potentially increase their capacity to host students. Innovative placements mooted or trialled include:

- multidisciplinary placements
- multi-site placements (one student placement is shared between different sites and/or agencies)
- multi-student placements (more than one student is supervised at a time)
- alternative supervision models (a staff member not recognised to supervise under the discipline's requirements acts as an informal supervisor and the formal supervision that meets the profession's requirements is provided by the educational institution)¹³

The availability of accommodation and transport options for students has been identified as a significant barrier to increasing student placements in small rural health services. This has also been identified as a barrier in community health services located in rural areas and, to some extent, in outer metropolitan areas. Lack of accommodation and transport were identified as barriers to increasing placement capacity in both a literature review and survey conducted by the Upper Hume Project.¹⁴ Overseas, the British Columbia Rural Academic Health Project (RAHP) identified that the “availability of student housing is the number one critical issue for recruiting students for rural placements”.¹⁵ It also notes that this housing needs to be provided at little or no cost to the student.

Programs that provide accommodation to students on placement, such as the University Departments of Rural Health Program, also acknowledge that the availability of accommodation is crucial to their success. The evaluation of the UDRHP stated that:

*“Increasing levels of support available from UDRHs for accommodation and transport costs of placements would encourage students to undertake placements who might currently be deterred due to the costs of doing so, and thus provide additional encouragement for students to be exposed to rural practice.”*¹⁶

A number of successful student placement programs in rural areas provide accommodation at little or no cost to students, and/or transport subsidies. For example, most UDRHs provide accommodation support for students and some provide transport support. The Combined Universities Department of Rural Health in Western Australia operates a dietetics student



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placement program in the East Kimberley region. This program relies on the support of local organisations to facilitate these placements: Kununurra District Hospital provides low-cost accommodation for students in its nursing quarters and the WA Country Health service provides travel subsidies to offset some of the cost of transport to such a remote region.¹⁷

Queensland Health's Office of Rural Health undertook an audit of accommodation available for student placements across rural Queensland during 2008. The resultant guide lists around 140 accommodation options in 38 towns that adhere to the Queensland Government's Allied Health Professional Student's Accommodation Standards and are equivalent to a 3 star rating under the National Accommodation Star Rating Scheme.¹⁸ Accommodation listed varies from free Queensland Health supplied options to commercial options in caravan parks, cabins and private rental houses.

Each listing provides comprehensive information on the features of the accommodation, including cost, availability, location, distance to hospital and town centre, transport options, internet and telephone availability, fixtures and fittings.¹⁹ This allows students arranging a placement and services hosting placements to seek suitable and affordable accommodation.

The lack of availability of transport for students has also been raised as an issue in a number of reports. Transport issues occur both for students travelling to rural placements (either on a daily basis or to a residential placement) and travelling while on placement.²⁰ The cost and availability of transport are the major limiting factors, but there is also the risk of extended periods of driving in rural areas for those who are not used to this type of driving.²¹ Not all students have a car or drive and alternative transport options are not always available, practical or affordable.

The lack of resources for academic purposes is also an issue for students undertaking placements, particularly residential placements in rural areas where accessing these resources is more prohibitive. Provision of areas for students to study is seen as vital, as is internet access.²²

Constraints on increasing student placement capacity that relate to health service staff have also been identified in the review. These fall into three main categories: capacity to supervise (workload), willingness to supervise (staff attitude, organisation/team culture) and ability to supervise (training and experience).

The lack of capacity of staff to incorporate student supervision into their workload has been identified as a barrier to increasing capacity in a number of surveys, particularly in the community health sector.

Through a survey of 94 staff members from 14 community and women's health services across the north-west metropolitan region the NWMR Project sought to identify organisational information related to student clinical placements. These included policies and procedures, the level of staff supervision training and orientation procedures. The survey also sought staff suggestions for changes to allow increased placement activity.

The survey found that staff issues, especially time available and workforce size, were the most commonly raised issues in qualitative responses, along with allocation of physical space (as discussed above).²³

Through additional forums and surveys the NWMR Project asked participants to rank a list of potential barriers to their supervising student placements. The highest ranked response was "Not enough time, too busy seeing clients". The statement "No recognition for time spent with student (unable to allocate time for reporting purposes)" also ranked highly.²⁴



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The Upper Hume Project conducted a limited survey of staff in community health services and also found staff perception of a lack of time to supervise students was a barrier to increasing placements.²⁵

The Victorian Healthcare Association surveyed participants in student clinical supervision training courses that were funded under the Department of Health Clinical Supervision Training Grants in 2009. Surveys were to be completed by participating clinicians prior to commencing training, immediately after training and several months after the completion of training. The data has been analysed to give some insight into the barriers facing small rural health services from the perspectives of practitioners in those services. Responses from staff at small rural health services were examined exclusively, as there is little other data available showing the perceptions of this group.

Of the 2,384 responses to the three surveys (as at 11 November 2010), 409 were from staff at 22 small rural health services, representing around 17 per cent of responses. Respondents were asked to rate their confidence in various aspects of supervision (including responding to underperforming students, providing orientation, and supervising students from a discipline other than their own). The same series of questions was asked in each survey. A comparative analysis of this data showed that the confidence levels of SRHS staff were statistically indistinguishable from the responses of staff from other organisations.

Responses showed staff had a high level of confidence in providing orientation and imparting clinical skills, but were less confident about tasks such as providing critical feedback and managing difficult or underperforming students. Confidence levels increased after training across all questions.

A number of qualitative questions were also asked, including respondents' perceptions of barriers to providing effective clinical supervision to students. The themes of these responses can be grouped as follows:

- Time constraints – mentioned by over a third of respondents
 - *"Time restrictions due to workload impact on the effectiveness of our time with students. I believe that we can offer a useful and interesting placement for students but sometimes the time constraints restrict the student's experience"*
 - *"In my role there [are] no actual set hours for supervision of students. I feel that they need to have a supervisor who is there to work with them in a one-on-one situation not just wander past and ask them how they are going"*
- Lack of organisational support
 - *"There is insufficient time to effectively supervise students within the EFT allocated by management, resulting in a disjointed approach to their supervision and feedback"*
 - *"Company policies, support from managers, availability of resources and orientation packs, access to more experienced supervisors"*
- Difficulties communicating with training provider
 - *"...no communication between university and staff supervising students, there is some communication between the hospital and university but objectives often unclear to clinical staff"*
- Infrastructure issues within organisations
 - *"Availability of resources in own organisation, such as housing, computers, staff"*



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The NWMR Project identified the need for supervision to be included in the position descriptions of all staff that were identified as capable of providing supervision (i.e. considered able under the respective professional body's requirements). This was identified as an important strategy for overcoming staff reluctance to supervise and the perception that supervision is a task outside their regular duties, rather than an important part of those duties. As part of the project, participating agencies identified capable staff and updated position descriptions to include supervision.²⁶

Promoting the value of student placements to staff has also been seen as an important strategy for increasing capacity.²⁷ Promoting placements is about showing that supervision can be rewarding for the staff member and the organisation that students are valued by the organisation, and also that students add value to the organisation. The CRESCENT project identified a shift in the way students are viewed by staff as one of the six essential steps in developing community-based education:

"Shift from the traditional view of a student as a passive learner towards a new community based education (CBE) where they have an active role that is clear on what the student is competent and safe to do at each stage of the course:

Traditionally

- A burden/drain
- Time takers
- Unskilled
- Not useful
- No responsibility

New CBE Student

- Workforce assistance
- Saves time
- Has skills
- Is useful
- Has responsibility²⁸

The NWMR Project developed a poster to advertise the value of student placements to staff in community health services. The poster features the slogan "Students are our future" with photographs of students performing a variety of tasks. The poster text reads:

"By supervising today's students you will:

- o Challenge yourself
- o Help grow our workforce
- o Be part of a two way learning process
- o Be giving back to the profession
- o Benefit the community

A learning organisation is a healthy organisation.

Speak to your manager about supervising student placements" (See Appendix).

Providing training and support to staff has also been identified as an important strategy for enhancing both the quality of placements and the capacity for accepting them. The NWMR project identified the need for staff to attain a minimum standard of supervision training in order to feel confident to undertake student supervision.²⁹ The Department of Health Clinical Supervision Training Grants (2009) administered by the VHA provided financial support to organisations to train staff in supervision. Staff who undertook training as part of this grants program were asked to complete evaluation surveys before and after their training. Results indicated that confidence levels increased for staff as a result of participating in supervision training.

Minimising the time staff spend conducting orientation and ensuring that consistent and comprehensive information is provided to all students arriving for a placement have been identified as important strategies for agencies to increase placement capacity and quality.



The way in which orientation processes are managed within organisations has also been identified as affecting staff willingness to supervise placements or increase their supervision responsibilities. For many staff, orienting students is time consuming and is often repetitive (i.e. staff must provide the same information to each new student commencing a placement). The NWMR Project Student Placement Activity Report stated that “less than half the teams surveyed have a standard and effectively applied orientation process”.³⁰

Queensland Health provides an orientation website for all students across Queensland Health. This website (<http://www.health.qld.gov.au/sop/default.asp>) provides information on student placements for staff and students. A central part of the website is information on essential placement requirements. Topics include:

- Professional behaviour and responsibilities
- Code of conduct
- Confidentiality, privacy and documentation
- Workplace health and safety issues
- Immunisation and infection control
- Working with children checks
- Cultural diversity

(http://www.health.qld.gov.au/sop/content/essentials_homepage.asp)

Students are required to read and complete a Student Orientation Checklist stating that they have read and understood the information provided on the website. This process ensures students arrive at a placement with an understanding of the requirements of health services and staff can be assured that students do not need to be oriented to these aspects of their placement.

Bendigo Community Health Service is developing methods of orienting students to the service via the internet to relieve some of the time pressure for staff supervising students. It is expected that providing standard basic orientation prior to placement commencement will serve the purpose of ensuring all students receive the same information and release staff from the necessity of providing this information to each student arriving for placement (see Bendigo Community Health Services Case Study for further information).

Orientation processes can also be streamlined by organising a single orientation day for all students undertaking a placement in a particular time period. The NWMR Project recommended that universities hold one orientation session at a consistent time each semester for all students attending clinical placements during that semester.

3.2 Students

The review has identified a need to overcome reluctance by some students to undertake placements in community health and small rural health services. Reasons for this reluctance arise from students' personal circumstances, such as work and family commitments, the cost of placement (especially in rural areas for travel and accommodation) as well as student perceptions of the services themselves.

The Upper Hume Project undertook a literature review which examined the barriers to increasing student placements. The findings identified several barriers to undertaking rural placements from a student perspective:

- *“...Difficult to find affordable and appropriate accommodation for rural placements”*
- *“...Employment commitments of students”*



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- *"...Concerns about capacity and quality of placements for students" undertaking rural placements – some students may believe that they will not receive clinical experience in rural areas"*
- *"...Cost of student placements i.e. accommodation and meals" ³¹*

The Upper Hume project also surveyed 27 community health staff and 6 students who had completed a community health placement. The themes identified that relate to student barriers reiterate the findings of the literature review:

- *"...Lack of transport options for students*
- *Lack of [residential] accommodation for students*
- *Lack of coordination of placements...*
- *Mismatch of student placement opportunity" ³²*

A number of programs have successfully marketed placement opportunities in small rural health services to students. For example, in Canada the Interprofessional Rural Program of British Columbia (IRPbc) uses student testimonials on its website, highlighting the value of the experience to the student and encouraging others to participate. (<http://www.irpbc.com/>)

The evaluation of the University Departments Rural Health (UDRH) and Rural Clinical Schools (RCS) programs found that students who had undertaken rural placements were positive about the benefits:

"Many students... perceived benefits of placements to be far more comprehensive than simply the educational outcomes and included exposure to a rural lifestyle, the ability to work in teams, and exposure to a wider variety of clinical practice than a student might normally experience in an urban setting."³³

These positive perceptions could also be leveraged to promote the value of such placements to students. Community health services provide many of these same benefits to students, such as the opportunity to work in teams and experience different types of clinical practice to those in acute settings, which could also be marketed to students.

In addition, streamlined application and orientation processes are useful for students as well as for staff of health services. Programs providing clear application processes allow students to plan for their placements.³⁴ Orientation prior to a placement allows students to commence their placement with a clear understanding of the expectations the service has of them and what to expect from their placement. Some programs also provide student authored guides to rural placements, outlining what students can expect from a placement and the experiences of former students.

The University of Melbourne's Rural Health Academic Centre, which incorporates its RCS and UDRH, provides comprehensive information to all students undertaking a rural placement.³⁵ Information provided includes details of accommodation, staff contact information, safety and welfare information, student guidelines, university expectations and local area information. Students who have completed a placement at the RCS have also compiled a guide to the RCS on the local areas and what to expect from a rural placement from a student perspective.³⁶ These guides (available on the RHAC website) give students a clear understanding of what to expect from their placement and what is expected of them and minimises staff time spent answering queries.



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Sydney University's Broken Hill University Department of Rural Health (BHUDRH) provides a student manual detailing the placement application procedures, accommodation and orientation information, placement options and local area information. It also includes a placement checklist for students. The guide is available on the BHUDRH website along with additional information including discipline and location specific information, and an online application form. (<http://sydney.edu.au/medicine/drh/index.php>)

The provision of support to students via residential accommodation and transport has been mentioned in section 3.1.1 of this project review. This is especially important in order to attract students to rural placements.

Information technology is also critical to improving the quality and attractiveness of rural placements to students. The evaluation of the UDRH and RCS programs noted:

"The establishment of high-quality, cutting-edge videoconferencing technology in regional, rural and remote locations has been one of the greatest enablers, and also one of the most significant achievements, of the UDRH Program. Facilities which allow videoconferencing mean that distance learning opportunities can be provided to people hundreds of kilometres away from the lecture theatre, or that academic supervision can be given for individuals undertaking research projects in remote locations. Increasingly lectures are also available as podcasts so that students can access them at their leisure. Access to the internet and electronic access to university library resources have also facilitated health practitioners' ability to undertake continuing studies or research while remaining in practice. These same facilities have also made the option of rural placements and training more attractive to students."³⁷

3.3 Educational Institutions

A number of strategies that educational institutions can employ to improve placement quality and capacity have been identified by the projects, including providing clarity around placement expectations, standardising processes and agreements and providing clinical support to students while on placement.

Educational provider representatives were interviewed as part of the La Trobe University Community Health Services Teaching and Research Project on clinical placements in community health. There was some concern that services do not always cover the breadth of clinical experiences necessary for placements, particularly in some disciplines where there is an emphasis on clinical hours in acute settings, such as physiotherapy and medicine. This was coupled with time constraints around adding additional placements into health courses where there was no room in the curriculum for additional placement time. It should be noted that this group were, however, aware of the increasing importance of community-based care in the health sector, particularly in areas such as the management of chronic illness.³⁸

Community health service (CHS) chief executives and educational provider representatives saw the current relationships between universities and CHS as a constraint but have recognised its potential to contribute greatly to the ability to increase placement capacity.³⁹

The NWMR Project identified the following strategies that education providers and government bodies can use to support community health services:

- *"Providing CHS staff with professional development opportunities in supervision*
- *Standardising agreements between health services and tertiary institutions*
- *Assisting CHS staff with planning for students*
- *Creating a better understanding of the standard of students on placement*
- *Providing CHS staff with a clear understanding of the placement outcomes*



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- *Sending a consistent number of students each year to the partner CHS*
- *Ensuring that the number of students to be placed in a CHS to be known prior to the CHS annual planning phase*
- *Minimising the paper work involved with student supervision*
- *Sending supervisors a quarterly e-newsletter on supervision issues which includes upcoming training dates”*⁴⁰

Other strategies identified include educational providers (as well as staff) having clearly defined placement expectations to agencies and individual staff members, for example by

providing learning contracts and by ensuring staff have an understanding of the course curriculum.⁴¹

Standardising processes and agreements for placements between a provider and a service is also seen as essential to providing clarity around placements and streamlining the process.⁴²

The provision of clinical support to the host agency has been identified as a strategy to relieve time pressure on agencies, thus increasing capacity, ensuring that the quality of placements meet the provider’s expectations.⁴³

It has also been suggested that the responsibility for ensuring that students have completed police checks and, where required, working with children checks, is with the educational provider.⁴⁴

3.4 Coordination

Improving mechanisms for the coordination of student placements in health services and educational institutions was identified as a strategy for increasing placement activity in Community Health and Small Rural Health Services.

The projects have identified a need for improved coordination processes between education providers and services to improve placement quality and capacity. The focus of the Upper Hume and NWMR projects was the development of coordination models for student placements. Both projects highlighted that greater cooperation and coordination was fundamental to achieving improved placement capacity.

The Upper Hume Project developed a geographically-based coordination model involving community health services and education providers. Central to the model was the creation of a Student Placement Coordinator position responsible for placement coordination and liaison between the stakeholders. It was envisaged that a coordinator would have the following areas of responsibility: “Building relationships and the profile of student placements, students and supervisors, professional development and operational capacity and sustainability”.⁴⁵ A centralised database of placement requirements and opportunities was also considered essential to the success of the proposed model.⁴⁶

The NWMR Project also developed a coordination model in the first phase of its project. Central to this model was the development of a Placement Coordination Unit that would “provide a centralised negotiation point for placements across the Region”.⁴⁷ The model involved streamlining processes between tertiary institutions and community health services and developing better internal processes at community health services.



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Phase 2 of the NWMR project concentrated on capacity-building activities and strategies within community health services, particularly improving the structures and processes around student placements.

This phase of the project was influenced by the implementation of new placement networks, particularly the Clinical Placement Networks, La Trobe University's Clinical Schools Network and the University of Melbourne's Crescent Project. The focus in terms of region-wide coordination models and strategies thus shifted to building internal systems and processes within the participating agencies that would allow them to effectively engage with these new networks as they developed.

The NWMR Project also retained its focus on improving internal capacity and quality mechanisms within the participating agencies. This resulted in the development and implementation of several strategies over Phase 2 of the project. A number of these strategies are ongoing or continue to be developed in the participating agencies.

A primary strategy to this process was to create, define and streamline processes within the agencies for coordination of placements. This included establishing organisation-wide methods of registering placements and recording placement hours, incorporating placements into organisational planning processes, improving methods of prioritising and matching student placements, and streamlining and standardising orientation processes.⁴⁸

Other coordination strategies identified in the review as important to this process are standardising agreements between universities and health services, developing systems to process placement requests and matching students to placement opportunities.⁴⁹

The Clinical Placement Networks (CPNs) recently established in Victoria will take on a significant role in assisting to develop and implement locally-driven approaches to clinical placement planning, coordination and delivery that reflect the needs of stakeholders in the region.

It is anticipated that statewide network projects will contribute to improved planning and coordination at both a network and agency level. These projects include: data management system, CPN profiling and multilateral negotiations.

4. Conclusion

The projects examined on clinical placements in community health services and small rural health services uncovered a number of barriers to increasing capacity and quality, including issues around infrastructure, staff, students, agencies, educational institutions and placement coordination.

The literature also revealed many strategies for overcoming these barriers. Key strategies include:

- Centralising placement coordination within agencies and including placements in annual planning cycles
- Streamlining application and orientation processes for students
- Promoting the value of placements in the sector to staff and students
- Providing clarity around placement expectations for students
- Providing supervision training and support to staff
- Including placement supervision in all relevant position descriptions



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- Providing increased organisational support to students undertaking placements (such as accommodation, transport, IT, physical space within agencies)
- Investigating innovative placements (such as multidisciplinary, multi-student or multi-site placements)

This review has provided examples of the way many of these strategies have been tested in agencies in Victoria, interstate and internationally and shown to be effective in improving placement capacity and/or quality. The challenge is to replicate successful strategies across organisations and sectors. Many of these strategies could be implemented within organisational structures; however it also recognised that some of these strategies may require additional resourcing and support to make broad implementation achievable.



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7. Appendix A. NWMR Student Placement Project – Marketing Poster Aimed at Community Health Staff