Queensland Government

Queensland Health

06 June 2022

Hon Ruth Forrest MLC
Deputy President and Chair of Committees
Parliament of Tasmania
HOBART TAS 7000

Dear Hon Ruth Forrest

RE: Sub-Committee Inquiry into Rural Health Services in Tasmania.

Thank you for your request to provide information on nurse led models of care particularly in rural settings. Please see below for a summary of initiatives which are currently in practice in Queensland.

Project to establish a pathway for rural and remote generalist registered nurses

- The delivery of healthcare services in rural and remote Queensland is reliant on a sustainable nursing and midwifery workforce.
- Creating a long-term sustainable workforce requires the provision of both opportunities for immersion in rural and remote clinical practice and the right conditions for career development.
- In an attempt to address the current nursing workforce challenges in rural and remote locations, the Office of the Chief Nursing and Midwifery Officer and Office of Rural and Remote Health have commenced a joint project to establish a state-wide career pathway for Rural and Remote Generalist Registered Nurses.
- This project is an investment by Queensland Health which involves the development of a program to provide training and supports specific to the rural context and needs of communities. The project is partnering with key stakeholders across the five participating rural and remote hospitals and health services (HHS). The Health Services are:
    - North West
    - Torres and Cape
    - Central West
    - South West
    - Darling Downs
- The project aims to develop a program that will be trialled by 20 registered nurses who have at least 2 years' experience and are employed across the participating HHSs in FY22-23.
- It is envisaged that this program will evolve and be utilised as a workforce strategy within Queensland Health to attract clinical expertise and build capacity in rural and remote locations.

Queensland Health
Level 1, 15 Butterfield Street
Herston QLD 4006
Telephone 07 3708 5342
Website www.health.qld.gov.au
ABN 66 329 169 412

- Stakeholders have contributed to the design of the six month pilot program which is aligned with the Queensland Health Framework for Lifelong Learning for Nurses and Midwives (attached) and includes:
    - a suite of five core learning modules – Working in the rural and remote context; Critical Thinking and Clinical Reasoning; Advanced Assessment Skills; Leadership; and Primary Healthcare
    - elective modules which will be selected by the local health service based on local needs and the Clinical Service Capability Framework
    - underpinning supports including an individualised learning plan, clinical supervision (attached), mentoring and succession planning (attached) and clinical coaching
- Ongoing co-design and stakeholder engagement is crucial for the development of the program to meet the specific needs of communities and enable care to be provided closer to home by competent rural and remote generalist nurses.

Transition Support Programs (TSPs)

- TSPs are contemporary, post registration, clinically focused, continuing professional development programs. These programs are developed at Australian Qualifications Framework (AQF) level 8 for specific cohorts to assist the newly graduated or transferred nurse/midwife to acquire further general and speciality knowledge and skills in a logical, sequenced supported approach to effectively transition to work expectations.
  Please refer to page 37 of the *Framework for Lifelong Learning* for further details.
- There are a wide range of these programs, for example:
    - Adult Intensive Care
    - Paediatrics
    - Emergency
    - Neonatal
    - Renal
    - Perioperative
- These programs are managed within Queensland Health by statewide nurse educator groups coordinated by a State-wide Coordinator, a role rotated through by educators from the specialty practice area. Oversight is by the Nursing and Midwifery Directors of Education forum.
- Accessible, same principles of structure and target groups, coordination, and governance
- Modules from several TSPs relevant for rural, remote context i.e. bespoke program under consideration.
- Graduate Registered Nurses (RNs) and Midwives are either required to undertake TSP as a condition of employment or may be encouraged to undertake on employment.
- The Nursing and Midwifery Directors of Education have developed a generalised Enrolled Nurse TSP which does not meet AQF8 standards nor provide for articulation.

Strength with Immersion Model Programs

- Strength with Immersion Model (SwIM) Programs are highly successful Queensland Health learning programs designed to strengthen the future of the nursing and midwifery workforce by supporting novice to mid-career nurses and midwives to develop skills in a specialty area or context through clinical immersions.
- SwIM Programs accelerate the participant's engagement in learning within an area of specialty practice whereby the crucial elements are provided to assist safe transition into the workplace. They also enable the inexperienced nurse/midwife to function more effectively within a short period of time in the new area of practice to a basic safety standard with supervision.
- Registered Nurses from regional, rural, and remote locations have benefited from attending the SwIM Programs. For example, upskilling regional paediatric nurses in

chemotherapy administration has enabled the provision of patient care closer to home during the pandemic.

- The SwIM program supports learning pathways, including TSPs and are aligned with the Framework for Lifelong Learning for Nurses and Midwives. Since the inception of SwIM Programs in 2014 a variety of clinical learning opportunities have been offered including, but not limited to:
    - Paediatric
    - Neonatal
    - Community Nursing Practice
    - Mental Health
    - Rural and Remote
    - Aged Care
    - Perioperative Introductory Program
- The programs have adapted during the COVID-19 pandemic and whilst many offer participants a clinical immersion of between 2-4 weeks in a supernumerary capacity, some programs now offer a suite of clinical video's, clinical roadshows, or attendance at workshops (online or face-to-face) followed by support from the facilitator via a learning contract. For example, Paediatric educational resources and videos can be accessed via this link

Nurse and Midwife Navigators

- Queensland Health has invested in nurse navigator and midwifery roles to ensure patients or women and babies are supported through system navigation including those living in rural and remote locations. The Navigator role works to mitigate barriers and empower vulnerable people in their health journey, working across specialities for those persons who have complex health care needs to ensure person centred care in the right place at the right time. The Navigation role aligns to the four pillars:
    - Coordination of Care
    - Creating Partnerships
    - Improving Patient Outcomes
    - Facilitating System Improvements

Project to establish rural and remote nursing and midwifery workforce pool

- Clinical Excellence Queensland has allocated project funds to establish a nursing and midwifery rural and remote workforce pool.
- The project will be led by Central Queensland Hospital and Health Service (CQHHS) in collaboration with the Office of the Chief Nursing and Midwifery Officer.
- The project will review the re-establishment of a state-wide rural and remote nursing and midwifery workforce pool leveraging the learnings from the previous initiative led by CQHHS.

Workforce planning

- Addressing nursing and midwifery workforce shortages in rural Queensland prior to the COVID-19 surge was the focus of considerable effort. The immediate nursing and midwifery shortages sits within the context of historical workforce shortages in regional and rural locations, and a high level of retirement risk within the professions. This has been exacerbated due to the COVID-19 pandemic surge requirements.
- A key priority for the Department's Office of the Chief Nursing and Midwifery Officer (OCNMO) is to lead and advance policy that will build the sustainability for the professions of nursing and midwifery workforces for now and into the future. OCNMO is prioritising workforce planning activities to support sustainable nursing and midwifery workforces in rural Queensland.

- OCNMO will prioritise development of a midwifery workforce strategic action plan over the period April to June 2022 in response to reports of increased difficulty in recruiting midwives, particularly in some regional, and rural and remote centres.

Thank-you again for the opportunity to contribute to inquiry into Rural Health Services Tasmania.

Yours sincerely

Dr Jocelyn Toohill
Acting Chief Nursing and Midwifery Officer
Clinical Excellence Queensland
Queensland Health

June 2018

Clinical **Excellence** Division
Creating solutions for better healthcare

Queensland Government

Framework for Lifelong Learning for Nurses and Midwives - Queensland Health.

Published by the State of Queensland (Queensland Health), June 2018

For more information contact:

Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division, Department of Health, GPO Box 48, Brisbane QLD 4001, email ***chiefnurse-office@health.qld.gov.au***.

An electronic version of this document is available at ***https://qheps.health.qld.gov.au/nmoq/professional-capability***

This Version of the 'Framework for Lifelong Learning for Nurses and Midwives - Queensland Health (2018) will remain current until 2021.

Authors

Dr. Robyn Fox	Nursing and Midwifery Director Education, Royal Brisbane and Women's (RBWH)
Dr. Catriona Booker	Assistant Nursing Director Education Service Coordination, RBWH
Adam Turbutt	Nurse Educator RBWH, Metro North Hospital and Health Service (Development of Models/Diagrammatic Representations and Editorial Review)

Acknowledgements

Editorial Review Group

The authors of this Version of the *Framework for Lifelong Learning for Nurses and Midwives - Queensland Health* (2018) wish to acknowledge:

- Sponsorship and professional support provided by the Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division - Department of Health.
- Guidance and direction provided by the Executive Director Nursing and Midwifery Forum.
- Support and encouragement offered by the Executive Director of Nursing and Midwifery and Community of Practice members - Metro North Hospital and Health Service (MNHHS).

Office of the Chief Nursing and Midwifery Officer

- Shelley Nowlan, Chief Nursing and Midwifery Officer, Clinical Excellence Division
- Michelle Gunn, DON Professional Capability, Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division
- Anne Garrahy - ADON Professional Capability, Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division
- Jocelyn Toohill – DOM Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division

Metro North HHS

- Allison Bowen - ADON Education Redcliffe Hospital, Metro North HHS
- Christine Burridge - AND Education RBWH, Metro North HHS
- Megan Lowe - ND Education TPCH, Metro North HHS
- Sharon Ragau - NE Caboolture Hospital, Metro North HHS

Metro South HHS

- Bernadette Thomson - A/ND Education Princess Alexandra Hospital, Metro South HHS

Gold Coast HHS

- Lyn Armit - ND Education Gold Coast University Hospital, Gold Coast HHS
- Dr. Kathleen Baird - DONM Education - Women-Newborn - Children's Services, Gold Coast HHS

Children's Health Queensland

- Dr. Adrienne Hudson - Nurse Researcher, Learning and Workforce Development, Lady Cilento Children's Hospital Children's Health Qld

Central Queensland

- Julie Kahl - ND Education and Research Rockhampton Hospital, Central Queensland HHS

Central West

- Chris Bertolo - A/Director of Nursing, Longreach Hospital, Central West HHS Darling Downs

Darling Downs

- Helen Towler - Nursing Director Baillie Henderson Hospital, Darling Downs HHS

Mackay

- Christopher Churchouse - ND Education and Research Mackay Hospital, Mackay HHS

North West

- Julie Parry - ND Professional Practice Mt Isa Hospital, North West HHS

Torres and Cape

- Sarah Worth - DON Clinical Education and Practice Development, Torres and Cape HHS

Townsville

- Debbie Maclean - ND Education and Research Townsville Hospital, Townsville HHS

Wide Bay

- Cheryl Steers - ND Clinical Program Manager Bundaberg Hospital, Wide Bay HHS

Sunshine Coast

- Annette Faithfull-Byrne - Nursing Director, Practice Development Sunshine Coast University Hospital, Sunshine Coast HHS

- The original authors, reviewers and editors of the:
  - Queensland Health Nursing and Midwifery Staff Development Framework (QHNMSDF) (2004)
  - Queensland Health Building Blocks of Lifelong Learning Framework for Nurses and Midwives in Queensland (2010)
  - Metro North Hospital and Health Service Framework for Lifelong learning for Nurses and Midwifes working within MNHHS (2015) from which the 2018 version is based.

This icon is used throughout the Framework to draw attention to the 'Overarching Caveat' statements below.

This icon is used throughout the Framework as a formal way to direct people's attention to an individual/position's responsibility or to information for consideration in decision-making/application to other areas.

Overarching Caveats

- The terms *'person-centred'* and *'consumer'* have been used throughout the *'Framework for Lifelong Learning for Nurses and Midwives - Queensland Health* (2018)', Nursing/Midwifery Career Pathways and other supporting resources to reflect the care philosophy within both the nursing and midwifery professions.
- While it is acknowledged that the term 'specialisation' can be applied in a variety of contexts, please note that within the Lifelong Learning Framework and other supporting resources the midwifery profession is less likely to apply the term 'specialisation' in practice. As such, the term 'specialisation', and sections referring to 'specialisation' are only to be applied to the nursing profession.
- The Office of the Chief Nursing and Midwifery Officer is leading the development of midwifery career pathways and classification structure. Future versions of the Framework and other supporting resources will reflect any amendments to the midwifery career pathways. In the interim current resources can be applied as relevant to support the midwifery profession.

Table of Contents

1. Intent 5

2. Applicability 5

3. Glossary 7

4. Assumptions 8

5. Nursing and Midwifery Scope of Practice and Professionalism 9

6. Nursing and Midwifery Education Context 10

7. Lifelong Learning 15

8. Continuing Professional Development (CPD) 17

Standards for CPD 18

8.1 Workplace Learning 19

8.2 Career Development 20

Standards for Career Development 21

8.2.1 Career Pathways 22

8.2.2 Learning Pathways 23

Standards for Learning Pathways 24

8.2.3 Nursing Specialisation Pathways 28

9. Clinical, Professional and Organisational Learning 30

Standards for Clinical, Professional and Organisational Learning 30

9.1 Clinical Learning 31

9.2 Professional Learning 32

9.3 Organisational Learning 34

10. Orientation and Role Transition Support Processes 36

10.1 Orientation and Induction 36

Standard for Orientation/Induction 37

10.2 Transition Process 38

Standards for transition support process 40

10.2.1 Transition Support (TSP), Immersion (e.g. SWIM) or Accelerated Specialisation Programs 41

Standards for Transition Support, Immersion (e.g. SWIM), Accelerated Specialisation Programs 42

10.2.2 Early Career (New Graduate) Transition Support Considerations 43

New Graduate Additional Standards for Transition Support 44

10.3 Work Unit Development Maps 45

11. Clinical Placement and Student Support Processes 48

12. Supporting Relationships to Build Capacity 49

12.1 Preceptorship 49

Standards for Preceptorship 52

12.2 Coaching 53
12.3 Clinical Supervision 54
12.4 Reflective Practice 55
12.5 Mentoring 55
Standards for Mentoring 56
12.6 Succession Management 57
Standards for Succession Management 59
13 Underpinning Support Systems 60
13.1 Performance and Development Planning (PDP) 60
Standards for PDP 62
13.2 Advanced Standing/Recognition of Prior Learning (RPL) 62
14 Evaluation and Reporting 65
14.1 Evaluation 65
14.2 Reporting 67
15 Conclusion 68
16 Appendices 69
Appendix 1: Glossary 69
Appendix 2: Examples of CPD Activities 74
Appendix 3: Recommended AQF Levels for Nursing/Midwifery Classifications 75
Appendix 4: Examples of Work Unit Development Maps 78
Appendix 5: Broad snapshot of a sample Legislative, Mandatory and Requisite Skills Register 85
References 91

Figures

Figure 1: Nursing and Midwifery Education Model – Example 12
Figure 2: Example of Nursing and Midwifery Continuum of Lifelong Learning 16
Figure 3: Continuing Professional Development (CPD) Cycle 17
Figure 4: Broad Concepts of Generic Learning Pathways 26
Figure 5: Learning Pathway – Example Grade 5 RN/Midwife entering the workforce and progression via linear and non-linear means 27
Figure 6: Broad Sample of a Work Unit Development Map (example of a Learning Pathway) 46
Figure 7: Diagrammatic Representation of Preceptor Role 50
Figure 8: Diagrammatic Representation of Succession Management 58
Figure 9: Performance and Development Planning (PDP) Cycle 61

1. Intent

The *Framework for Lifelong Learning for Nurses and Midwives – Queensland Health* (the Framework) provides a scaffold for all teaching and learning considerations that 'value add' to achieving a sustainable, professional, capable, person-focused nursing and midwifery (nursing/midwifery) workforce that is respected for competence and quality.

However, it is recognised that there is often considerable variance in the nature, standard and quality of nursing/midwifery education access, offerings and resources across and within health facilities (Fox, 2013). Therefore, the Framework has been developed to be applicable to all nursing/midwifery contexts as an enabler to improve nursing/midwifery staff education and training experiences by informing strategies, policy, practices and behaviours.

As such, the Framework offers explanation about standards underpinning nursing/midwifery education services; key concepts associated with teaching and learning; strategies to support application; and standards to measure the effectiveness of educational activities.

Broadly the Framework content comprises:

- A structured approach to clinical, professional and organisational development opportunities for all classifications of nurses/midwives.
- Explanation of learning and development opportunities along a continuum of lifelong learning.
- Specific principles, standards, and exemplars to guide health services in:
  - the promotion, implementation and application of a culture of lifelong learning
  - applying pathways for career development and continuum of learning
  - foundational requirements for key programs of learning for all classifications of nurse/midwives particularly new graduate (novice) nurses and midwives (Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB9), 2016).
- Direction, planning, implementation, and evaluation strategies for workplace learning.
- A guide to attainment of relevant post-graduate awards (Henderson, Fox and Armit, 2008).
- Explanations applicable to individuals, groups, teams of nurses/midwives, and others that facilitate support processes, and guide a more collective overarching professional approach to building workforce capacity and capability thereby reducing variance in access, opportunity, expectations and standards.

2. Applicability

In creating an overarching resource that comprises a suite of standards for efficient and successful development and education of the nursing/midwifery workforce, the Framework is applicable for all nursing/midwifery groups and individuals. These include but are not limited to:

- The Office of Chief Nursing and Midwifery Officer Queensland who networks with Executive Directors Nursing/Midwifery (EDON/M) and Nursing/Midwifery Directors, Education across the State to support collective engagement in the development, education, and training of nurses/midwives within Hospital and Health Services (HHS) by promoting: innovation; access to opportunity; resource availability; and mitigation of variance in standards including capability and capacity.
- The Executive Director Nursing/Midwifery (EDON/M), HHS who liaises with executive members, education providers, and nursing/midwifery education service leads to: sponsor nursing/midwifery education and scholarly pursuits; set objectives

and performance targets; build and foster partnerships/relationships; accept jurisdiction for standards, workforce capacity/capability, and risk mitigation.

- Nursing/Midwifery Directors or Assistant Nursing/Midwifery Directors - Education who assume accountability for: education and professional vision; expert strategic and operational education leadership in applying the *Framework* intent; fostering translation of knowledge to practice and scholarly endeavours; effectively collaborating with the EDON/M, Directors of Nursing/Midwifery, Nursing/Midwifery Directors, Assistant Nursing/Midwifery Directors, interprofessional colleagues, internal and external partners (e.g. Higher Education Sector [HES]) to lead, and evaluate education initiatives to achieve expected outcomes.
- Directors of Nursing/Midwifery, Nursing/Midwifery Directors, and Assistant Nursing/Midwifery Directors who ensure the *Framework* is applied effectively to support: resource allocation; teaching and learning strategies; evaluation of service and workforce needs in attainment of a sustainable, professional, capable person-focused nursing/midwifery workforce valued for competence and quality.
- Nursing/Midwifery Educators who: reflect and regularly undertake self-assessment of role contribution and development needs to inform, and foster collaboration with others in the application of *Framework* tenets in determining educational activities; facilitate translation of knowledge to practice; and build capacity and capability to address clinical, professional and organisational learning needs (AHPRA, 2014; Fox, 2013).

  This role is integral in promoting application of the Framework tenets across the continuum of lifelong learning.
- Clinical Nurse/Midwife - Clinical Facilitators (Coaches) who role model, and use their expert clinical knowledge and skills in supporting and working collaboratively with Nurse/Midwifery Educators and others to apply the tenets of the Framework by undertaking development, education and training from an operational perspective within specific clinical contexts.
- Line Managers who: collaborate with Nurse/Midwifery Educators to support application of the tenets of the Framework; identify and evaluate workforce development needs, and monitor standards in liaison with Nurse/Midwifery Educators and others; operationalise relevant educational resources and support strategies.
- Clinical Nurse/Midwifery Consultants who: demonstrate and promote excellence in clinical and professional standards when working with others to apply the tenets of the Framework to practice.
- Nursing/Midwifery staff (all classifications) apply the tenets of the Framework to identify development gaps, shape expectations, reflect and formulate own development requirements in line with role and classification expectations.

  It is also the responsibility of each individual (all classifications) to generate and nurture a postive workforce culture that promotes, and supports reflection, inquiry, lifelong learning, workforce capacity/capability, professionalism, compliance with relevant standards, and development of the capacity and capability of others.

  A nurse/midwife who is responsible for development/education outcomes, standards and nursing/midwifery staff performance (e.g. Nursing/Midwifery Directors, Nurse/Midwifery Unit Managers, Nurse/Midwifery Educators, Clinical Nurse/Midwife – Clinical Facilitators) demonstrates sound awareness of, and ability to apply the tenets of the Framework in order to: effectively generate dialogue; uphold a common language/nomenclature and expectations to foster support and engagement in lifelong learning; and establishment of best practice, and workforce outcomes.

- Newly graduated nurse/midwives are provided:
  - additional learning support and access to programs of learning that accelerate their transition into the workplace and consolidate learnings to enable achievement of expected standards, and the provision of self-sufficient, safe competent care.
  - opportunity for supervision and support by experienced nurses/midwives who offer objective feedback regarding performance, and facilitate confidence and competence in achieving relevant standards of practice; and assist by accelerating a pathway to clinical specialisation ( i.e. nursing profession).
- It is the responsibility of each nurse/midwife (all classifications) to share their knowledge and practice in a professional manner (as per the Nursing and Midwifery Board of Australia (NMBA) Codes of Conduct (Principle 5) (NMBA, 2018a and b) when supporting, directing, teaching, supervising and assessing nursing/midwifery students, new graduates and other nursing/midwifery colleagues to achieve best practice care.
- The Framework can be used to provide others with a clear description of the nature, scope, standards, outcomes and reporting processes applied in the development (including Continuing Professional Development), education, and training of nurses/midwives within a HHS/facility/directorate/service.
- This facilitates:
  - resource allocation (fiscal, human and physical)
  - effective application of the Business Planning Framework (BPF) (OCNMO, 2016)
  - demonstration of outcomes aligned to professional and other standards
  - internal and external benchmarking
  - collective use of language and a broadly accepted approach to industry based nursing/midwifery workforce development, education and training across Queensland.

3. Glossary

To clarify terms used within the *Framework* pertinent to nursing/midwifery, education and to promote collective use and appreciation of consistent terminology a Glossary is provided as Appendix 1. This Glossary is important given that many terms, in particular those related to workplace and continuing professional development are often used interchangeably. Without clarification of terminology, confusion and impact on achievement of shared language, appreciation of requirements, and application of the *Framework* tenets and educational outcomes may be compromised (Quinn and Hughes, 2013).

4. Assumptions

- The HHS/facility/directorate/service values a sustainable, competent, compassionate, innovative, professional and capable person-centred nursing/ midwifery workforce that is encouraged to participate in ongoing self-reflection and continuous learning.
- Person-centred care, quality improvement, translation of knowledge into practice, and repeated demonstration of competence underpins all education/training and nursing/midwifery developmental activities.
- All nursing/midwifery education/training initiatives, activities and resources reflect minimum standards of registering authorities, professional bodies, legislation and HHS/facility/ directorate/ service (e.g. policies, procedures).
- The principles of Performance and Development Planning (PDP) underpin negotiation of teaching and learning and support processes required by each nurse/midwife.
- The application of a career pathway enables the current and emerging workforce to plan a development journey which facilitates acquisition of requisite knowledge and skills for role expectations.
- The workplace environment supports a culture that fosters the development of nursing/ midwifery staff, and lifelong learning that meets clinical, professional and organisational needs.
- The context of the workplace setting is fundamental to realistic and meaningful engagement within the healthcare team; achievement of clinical skills, knowledge, and interprofessional socialisation that cultivates productive and competent contribution to health consumer outcomes and the health care system.
- Teaching and learning principles, and support processes are applied flexibly to accommodate variance in learning needs, styles and competence from a novice practitioner to the more experienced professional colleague.
- Novice practitioners are provided with context specific learning pathways, foundational resources, and additional support processes to foster effective transition to professional practice and engagement in lifelong learning.
- Each nurse/midwife assumes personal accountability and responsibility for professional engagement, their lifelong learning pathway and effective utilisation of learning opportunities, and workplace offerings (e.g. Orientation, Transition Support Processes, Continuing Professional Development, Succession Management).
- A shared perspective of nomenclature, foundational requirements, principles and standards minimises variance between HHS/facility/directorate/service offerings and promotes equity and access for nursing/midwifery staff.
- All organisational activities benefit from workplace learning that is viewed as fundamental in striving for professional excellence, standards, evidence based practice and optimal outcomes.
- Training and education are valued, and viewed as fundamental to developing capability and striving for excellence. Similarly, industry employed Nurse/ Midwifery Educators are valued and respected for their engagement and contribution in developing and supporting nurses/midwives in continuous improvement, translation of evidence into practice and lifelong learning.

5. Nursing and Midwifery Scope of Practice and Professionalism

The scope of practice of the professions is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that the individual nurse/midwife is educated, competent and authorised to perform (NMBA, 2007). The overall scope of practice depicts an evolving and dynamic range of responsibilities, that reflects the 'outer limits' or boundaries for the professions and all of the roles and activities of practice (NMBA, 2007; CRNNS, 2015). Therefore, it forms the foundation from which governments determine legislation, governing bodies prepare standards of practice, educational institutions prepare curricula, and employers prepare role descriptions (Nelson et al., 2014). Moreover, the scope of practice of each individual nurse/midwife is influenced by the context in which they practice, the requirements of the employer and the needs of health care consumers and families (Nelson et al., 2014). As such, particularly in the nursing profession an individual's scope of practice will vary according to the activities, functions, responsibilities and accountabilities for which they are educated, authorised and competent to perform. Although midwives are considered already competent to scope of practice at graduation organisational and other barriers may exist that influence scope application (ICM, 2013; NMBA, 2018d). Consequently, the scope of an individual nurse/midwife's practice may be narrower than the scope of the nursing/midwifery professions (NMBA, 2007; Nelson et al., 2014).

Hence, achievement of optimal scope of practice requires a complex interplay of professional attributes, experience, learning, scientific knowledge and critical thinking by the individual nurse/midwife to perform at the highest level of competence (knowledge, skills and judgment) and confidence, and thereby make the utmost contribution to outcomes (CRNNS, 2015; OCNMO, 2013 and b).

There is little consensus in the literature regarding the meaning of professionalism (Mark, Salyer and Wan, 2003; RNAO, 2007). However, in nursing and midwifery, a number of generally recognised descriptors or attributes have been noted in international literature (Mark, Salyer and Wan, 2003; RNAO, 2007). These include: knowledge based on evidence; a spirit of inquiry; intellectual and individual responsibility/accountability (relevant to role authorisation); autonomy (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]); specialisation ; innovation and vision; collegiality and collaboration; and a well-developed group consciousness (ethics and values) (Mark, Salyer and Wan, 2003; RNAO, 2007). Achievement of professional tenets and optimal scope of nursing/midwifery practice requires the individual to: be familiar with the legislation and professional body requirements; demonstrate professional standards; and put into action the values and attributes of the profession and organisation when providing care and collaborating with consumers, nurse/midwifery colleagues, interprofessional health care team members and others (e.g. external providers, HES) (CRNNS, 2015; OCNMO, 2013a and b).

6. Nursing and Midwifery Education Context

Realisation of the assumptions, and professional and individual scope of practice optimisation considerations underpin the effective application of the Framework and achievement of expected nursing/midwifery education outcomes in the workplace. Therefore, comprehensive appreciation of the scope of opportunities to engage, the types of activities nurses/midwives undertake, and the extent and nature of support, supervision, and guidance provided become fundamental to evaluating how individuals learn and apply principles to workplace practices (Fox, 2013). As such, Fox (2013) identified that Nurse/Midwifery Educators play a key role in the ongoing development of nurses/midwives in obtaining requisite knowledge and skills for providing care and managing within complex healthcare environments. Nurse/Midwifery Educators enhance partnerships, facilitate translation of knowledge to practice, support practice standards to build a sustainable, professional, and capable workforce by adjusting focus to address learning, and education needs within the context of practice (Fox, 2013).

Application of the tenets of the Framework are reliant on a shared governance approach. Therefore, depending on specific circumstances, Nurse/Midwifery Educators and others (e.g. Clinical Nurse/ Midwife – Clinical Facilitators, Clinical Coach) with an education emphasis will focus on one or a combination of the tenets of the Framework to enable workplace development opportunities for nurses/midwives to assist achievement of practice standards and optimal outcomes. Accordingly, Nurse/Midwifery Educators support a culture of learning in the workplace; function as custodians of standards; act as a resource 'safety net' and advocate for the achievement of best practice (Fox, 2013). Therefore, a core responsibility of the Nurse/ Midwifery Educator role is to support self-directed lifelong learning in partnership with other colleagues to contribute to the continuing development of the individual and the profession (Fox, 2013).

The responsibility of the individual is to engage in active lifelong learning as continuous, collaborative, self-directed learning applicable to one's profession as well as all aspects of life. Learners should be self-directed and take responsibility for setting goals, identifying resources for learning, and reflecting on and evaluating their learning. By integrating work and learning, the individual acquires, engages and applies knowledge within the authentic context of work to achieve desired outcomes (Fischer, 2014).

It is also acknowledged that to achieve optimum utilisation of the nursing/midwifery workforce there needs to be acceptance that care is not just a collection of tasks. As such, the context of care, consumer and population health needs, workforce knowledge, skills and mechanisms in place to progress the individual's capacity to meet work place expectations must be considered in relation to professional principles, codes of practice, standards and obligations (NMBA, 2018a andb; Besner et al., 2005; CRNNS, 2005; White et al., 2008). Moreover, nursing and midwifery practice is not restricted to the provision of direct clinical care, but rather extends to any role where a nurse/midwife uses their skills and knowledge to inform and optimise practice to meet role expectations.

Therefore, in working towards achieving suitable clinical, professional and organisational outcomes, it is contended that the employer has a responsibility to provide a learning environment that assists staff to effectively manage change, supports career development, facilitates remedial education, and promotes self-directed learning (Billet, 2016; Fox, 2013; Schoonbeck and Henderson, 2011). The significance of ongoing learning and individual development to maintain work practice currency and professional competence is further reinforced by health professional registration mandatory requirements in Australia (AHPRA, 2014), governance, and systems. In applying the tenets of the Framework, HHS/facility/ directorate/service structures, governance and philosophy need to be incorporated in all educational support activities to foster

consistency in direction, and optimise best practice, and other intended outcomes.

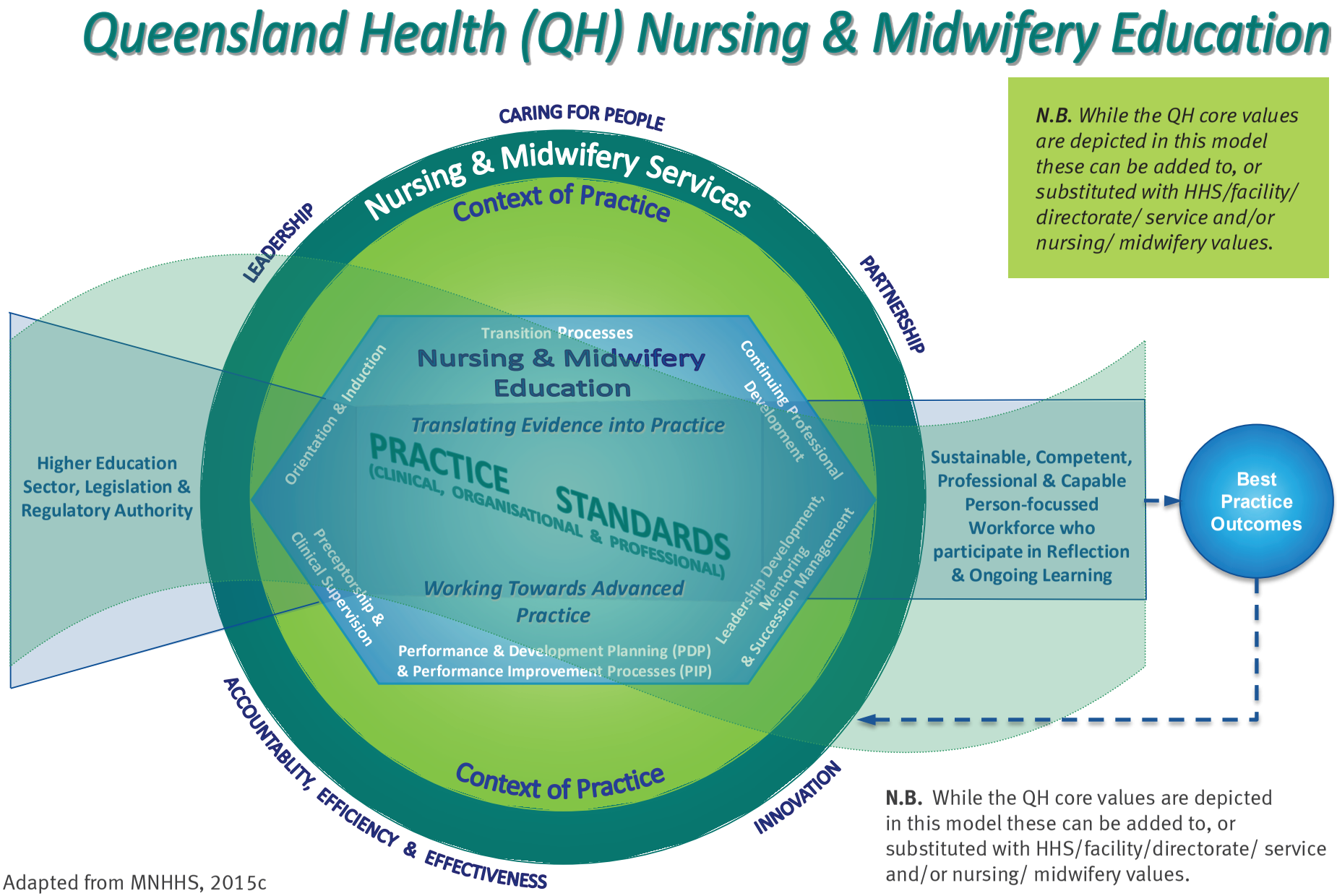
Additionally, documents that underpin fiscal and workforce objectives, strategic direction, and education, training and research fundamental requirements have been used to inform the *Framework*. These include (but are not limited to):

- *Queensland Health (QH) Health and Wellbeing Strategic Framework 2017 to 2026* (Queensland Health, 2017a)
- *Department of Health (DoH) Strategic Plan 2016 – 2020* (Queensland Health, 2014)
- Hospital and Health Service Strategic Plan (as relevant to the HHS)
- *DoH Health Service Plans and Strategies* (Queensland Health, 2016a)
- *My health, Queensland's future: Advancing health 2026* (Queensland Health, 2016b)
- *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026* (Queensland Health, 2016c)
- *Advancing health service delivery through workforce: A strategy for Queensland 2017–2026* (Queensland Health, 2017b)
- Queensland Health Workforce Diversity and Inclusion Strategy 2017-2022 (Queensland Health, 2015)
- *Advancing rural and remote health service delivery through workforce: A strategy for Queensland 2017-2020* (Queensland Health, 2017c).
- *Queensland Health Leadership Development Pathway* (Queensland Health, 2017d)
- *NMBA Professional Standards* (Refer to Section 9.1: Clinical Learning)

Sound comprehension of HHS/facility/directorate/service plans, strategies and roles encourages engagement in critical reflection by the nursing/midwifery profession in respect to their responsibility to lifelong learning. Specifically, the development of a HHS/facility/directorate/service Nursing/Midwifery Education Plan/s emphasises vision, educational priorities, key strategies, actions, and indicators (e.g. key performance indicators) undertaken to embed and foster the effective application of the tenets of the Framework. Plans should be developed in collaboration with nursing/midwifery education services, updated annually and endorsed for application by nursing and midwifery governance across HHS/facility/directorate/service to promote consistency in offerings, and provide ability to measure and benchmark outcomes. As such, it is critical that nursing/midwifery leaders, line managers and Nurse/Midwifery Educators have a comprehensive appreciation of the intent of the Framework and supporting Education Plan/s. Additionally, Nurse/Midwifery Educators and nurse/midwifery leaders require a thorough grasp of their classification and role (through reflective processes) to effectively lead, support, and nurture the development of others to achieve expectations (MNHHS, 2017; Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).

To assist nursing/midwifery stakeholders gain an overarching perspective of internal and external influences and concepts impacting and supporting application of nursing/midwifery education services through knowledge translation, partnerships and capacity building initiatives the following *Nursing and Midwifery Education Model* ***(Figure 1)*** has been developed (Queensland Health, 2018 adapted from MNHHS, 2017). This Model ***(Figure 1)*** is provided as an example that can be used by Nurse/Midwifery Educators, nurse/midwifery leaders, teams, and individuals to promote reflection and dialogue regarding concepts underpinning nursing/midwifery education, and the intent of the *Framework*.

Figure 1: Nursing and Midwifery Education Model – Example



N.B. *While the QH core values are depicted in this model these can be added to, or substituted with HHS/facility/ directorate/ service and/or nursing/ midwifery values.*

Adapted from MNHHS, 2015c

N.B. *The figures contained within the 'Framework' have been included to provide examples to those responsible for the development/education outcomes and nursing/midwifery staff performance as well as for application to roles and responsibilities by all nursing/midwifery colleagues.*

The figures provide visual representations that demonstrate the complexity of nursing/midwifery roles, and responsibilities. They also assist those with stewardship in guiding others to support a continuum of learning, development, and career progression in an environment where healthcare takes precedence. HHSs/facilities/directorates/ services can incorporate context specific figures and/or models to further support theoretical explanation related to nursing/ midwifery education, lifelong learning and associated activities.

The model depicted as ***Figure 1*** is a diagrammatic representation of the internal and external factors, and processes that influence industry workplace nursing/midwifery education engagement, actions and outcomes.

The intent of including this example model ***(Figure 1)*** is to emphasise the notion that nursing/midwifery education services are:

> *"…dynamic and construct learning pathways and a culture of workplace learning via interface with external/internal partners. This occurs simultaneously while functioning as a custodian in building a capable, sustainable professional workforce who demonstrates best practice care, and compassion for consumers" (Fox, 2013 p.199).*

Positioning nursing/midwifery education at the centre of the Model ***(Figure 1)*** depicts the situation and contribution of nursing/midwifery education services in location and context. The core responsibilities of Nurse/Midwifery Educators depicted around the hexagonal boarder (e.g. transition processes, mentoring, and preceptorship) illustrate the complexity of nurse/midwifery core activities in translating evidence into practice, and working towards advancing practice. At any time, depending on specific circumstances the focus is either singular or a combination of core activities.

Each component of the representation ***(Figure 1)*** is relational as in practice every educational core activity is impacted and managed according to internal and external influences.

The concentric circles forming the outer aspects of the representation around the central hexagon ***(Figure 1)*** identify internal HHS and organisational relational processes. These include context of practice (e.g. facility/ directorate/service capability, teams, and individuals), governance, core values (◊ refer to footnote on ***Figure 1***) and structure of nursing and midwifery. It is important that each of the internal relational process is considered by the Nurse/Midwifery Educator in respect to effective achievement of core activities (as depicted in the hexagon).

External relational influences such as the HES (e.g. curriculum, student placements, and new graduates), legislation, and regulatory authorities (e.g. NMBA, AHPRA) are depicted in the form of a funnel across the mid-section of the model ***(Figure 1)***. The intent of this representation is to demonstrate the integral and constant influences that are purposefully directed to nursing/midwifery education services across the continuum to support lifelong learning. As such, these influences are addressed by nursing/midwifery education services through the application of the depicted core responsibilities to optimise achievement of a sustainable, professional, and capable person-focused workforce at all classifications of nursing/midwifery. Realisation of these core responsibilities should result in each profession achieving best practice outcomes.

The wave form depicted weaving through the model represents the integral nature of ongoing professional obligations to achieve optimum practice standards in fulfilment of the *Nurses and Midwives (Queensland Health) Award – State 2015 Generic Level Statements*

(hereafter referred to as the Award) (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) for each classification. Intrinsically, every component of the model is strongly influenced by practice standards.

Therefore, Nurse/Midwifery Educators and other key stakeholders are encouraged to review the *Award*, professional requirements and practice standards to engage in critical thinking and reflection about how these are applied, supported and evaluated to achieve expected nursing/midwifery outcomes (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).

While not prescriptive the Framework is intended to inspire, and challenge Nurse/Midwifery Educators, leaders and others to consider how key principles identified are applied in a dynamic proactive manner to provide structure and achieve consistency across nursing/midwifery education industry services within Queensland.

Additionally, it is acknowledged that there is not one 'right way' to provide or engage in teaching and learning for the nursing/midwifery profession as this approach would leave little room for reflection, questioning or change. However, the content sections, models and standards comprising the Framework provide a platform to support nurses/midwives structure ongoing learning in their practice environment to attain their professional goals, clinical standards and requisite organisational information. As such, ongoing learning and reflection are fundamental concepts of the *Framework* which if supported effectively should generate engagement; questioning; change in behaviour and practice that benefits the individual, profession, and the organisation (Fox, 2013).

The role of the Nurse/Midwifery Educator and others (e.g. Clinical Nurse/Midwife - Clinical Facilitators, Clinical Coach) participating in, and supporting reflective practice and ongoing learning assists deliberation on their own practice, and should facilitate seeking new ways to build professional knowledge, develop learning communities and a culture of lifelong learning. A commitment to a strong culture of learning is critical in developing the profession and encouraging participation in ongoing training, education and research (Fox, 2013).

***N.B.** The content that follows is offered in sections to assist the reader explore concepts related to nursing/midwifery teaching, learning, standards and requisite outcomes. The Framework design provides opportunity to focus on singular or multiple section/s according to priority needs. While the reader may at times gain a view there is some repetition of content in various sections of the Framework, the intent is to provide a fulsome resource that reinforces salient principles, and highlights the association between particular concepts to enable linkage and/or application of individual section content. However, it is recommended that the Framework is read in entirety and the relevant content, models, tenets and standards are noted before attempting to apply workforce development activities or initiating Performance and Development Planning (PDP) with staff.*

The premise is learning and development are essential components of professional practice, and alignment of these to PDP enables support for a culture of learning (Fox, 2013). As such, alignment of learning to performance and development is an underlying thread throughout the *Framework*.

To achieve the expected outcomes of a sustainable, professional person-focused workforce that participates in reflection, and ongoing learning, a culture of lifelong learning is required within the workplace. Fundamentally, lifelong learning is essential in maintaining contemporary skills, knowledge and ability to translate contemporary evidence effectively into practice.

7. Lifelong Learning

To maintain a contemporary knowledge base and best practice, it is important that nurses/midwives demonstrate commitment to lifelong learning (Bridges, Herrin, Swart and McConnell, 2014; Chichester, 2011; Cleary, Horsfall, O'Hara-Aarons, Jackson and Hunt, 2011; Collins, 2009; Fischer, 2014). In the rapidly changing health care environment it is improbable to assume that knowledge and skills remain static. Hence to inspire nurses/midwives to provide contemporary, relevant, evidence-based care it is essential that they are supported in their workplace and other learning (Kitto, Goldman, Schmitt and Olson, 2014). Fostering learning; supporting retention of new knowledge and skills; and building capacity encourages active participation in lifelong learning, which is essential to engagement enhanced through enquiry; and a healthy organisational learning culture.

To achieve this commitment there is an expectation that nurses/midwives actively participate in learning activities that assist in developing, and maintaining their continuing competence, enhance their professional practice, and support their career goals (Pool, Poell and Cate, 2012).

Hence in the current context lifelong learning is defined as:

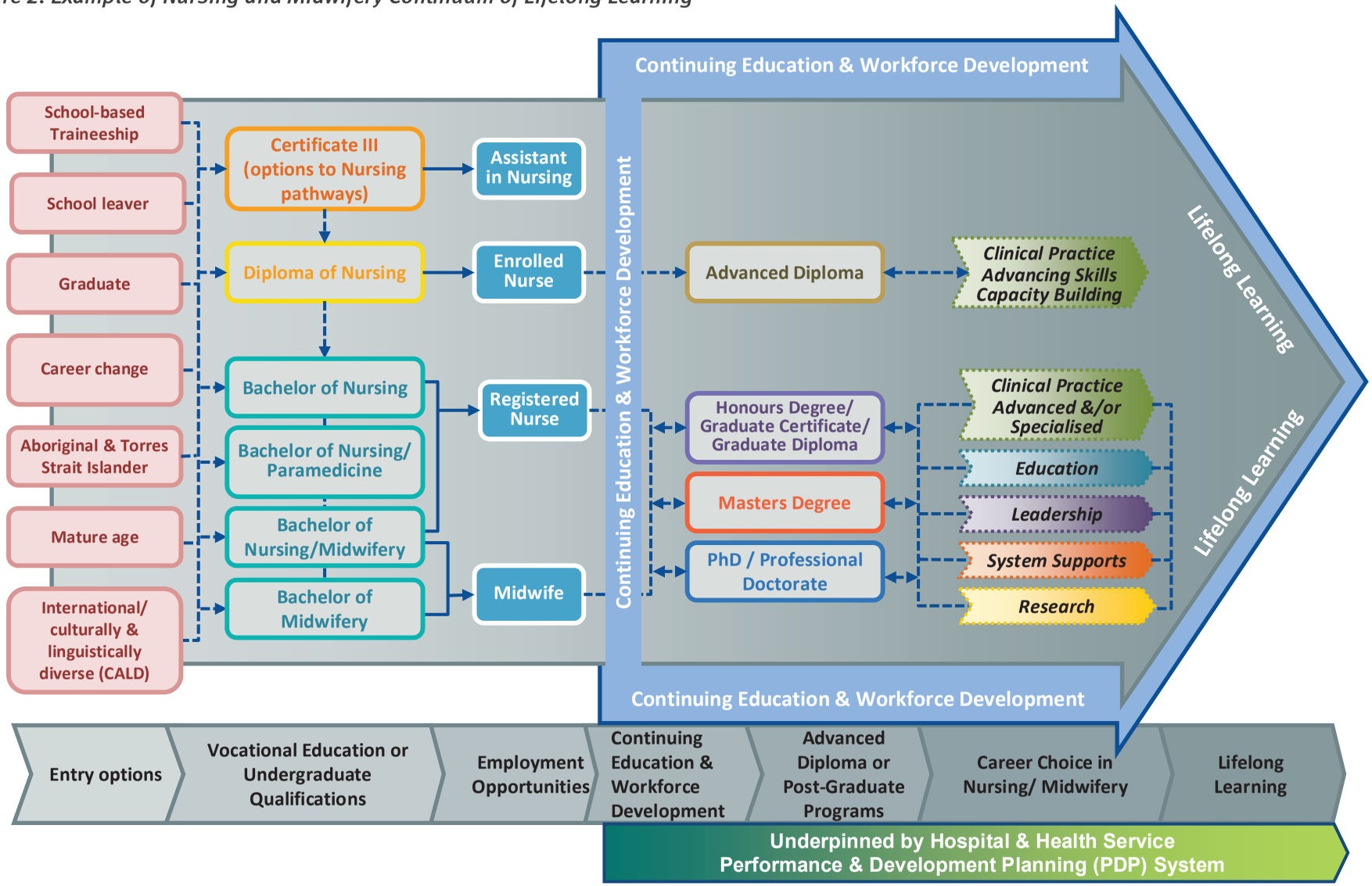
> *the provision or use of both formal and informal learning opportunities throughout people's lives to foster the continuous development and improvement of the knowledge and skills needed for employment and personal fulfilment (Collins, 2018).*

The expectation for continuation of learning to acquit one for work roles and life, ***Figure 2*** is provided as a linear example of various pathways to enter the nursing/midwifery profession and continue to develop, learn and gain relevant academic awards throughout one's working life.

Lifelong learning should be a process of continuous learning with the aim of improving knowledge and skills from a personal, civic, social and/or employment perspective (Laal, 2011; Stella, 2012). Engagement in lifelong learning is particularly important given an individual's career is influenced by many things, such as interests, age, education, families and cultural values, all of which change over time. Therefore, it is generally expected that individuals make changes throughout their career, participate in lifelong learning to keep pace with skill changes and role requirements (Laal, 2011; Stella, 2012). Lifelong learning however, is more than adult education and/or training but rather a mindset and a custom for individuals to acquire (Stella, 2012). The premise is that individuals are, or can become, self-directed learners, who recognise the value in engaging in lifelong learning (Tight, 1996). Additionally, effective application of the principles of the Business Planning Framework (OCNMO, 2016) will facilitate ongoing educational opportunities. However, it is recognised that practicalities such as financial implications and family commitments may impede the notion of lifelong learning, and access to opportunities (Tight, 1996) which may influence engagement in continuing professional development (CPD), workplace learning and outcomes.

Moreover, Quinn and Hughes (2013) identify that the terms lifelong learning and continuing professional development have been used interchangeably. Consequently, for the purpose of the *Framework*, application and clarity of terms, nurses/midwives participating in CPD are viewed as lifelong learners who engage in context-related learning that should facilitate change, develop new beliefs, and contribute to a culture of learning (Billett, 2016; Cochran-Smith and Lytle, 2001; Ganser, 2000; McLaughlin and Zarrow, 2001; Morgan, Cullinane and Pye, 2008; Murphy and Calway, 2008; Young and Patterson 2007).

Figure 2: Example of Nursing and Midwifery Continuum of Lifelong Learning



Caveat:

- **Continuum of Lifelong Learning progression is not necessarily linear.**
- **Some ENs may progress to a EN Advanced Skills (ENAS) dependent on demonstration of skills & knowledge; opportunities; & position availability.**
- **RNs/Midwives may choose to progress their career path from Grade 5 to a higher role classification as per the *Award* (2015) dependent on demonstration of skills & knowledge; opportunities; & position availability.**
- **ENs, RNs & Midwives are able to advance their scope of practice based on training & successful assessment.**

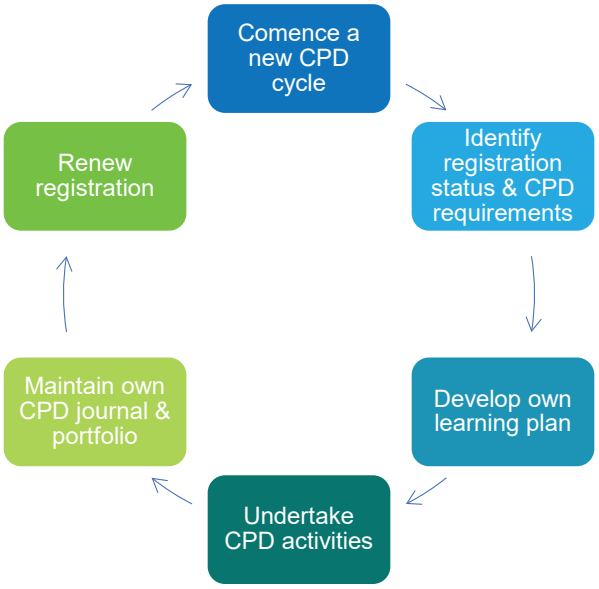
8. Continuing Professional Development

Continuing Professional Development (CPD) is viewed as a long-term process that includes opportunities and experiences systematically planned to promote growth and development in the profession (NMBA, 2016; Fahey and Monaghan, 2005; Ganser, 2000; Morgan et al., 2008). The aim of CPD is the development, not only of the competence of the professional, but also the personal and social skills of the individual (Sjukhusläkaren, 2005). Therefore, CPD is defined as the means by which nurses/midwives:

> *...maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives. The CPD cycle involves reviewing practice, identifying learning needs, planning and participating in relevant learning activities, and reflecting on the value of those activities (NMBA, 2016).*
>
> *....maintain, improve and broaden their knowledge, expertise and competence, to meet their obligation to provide ethical, effective safe and competent practice (NMBA, 2016).*

The Nursing and Midwifery Board of Australia (NMBA) *Registration Standard: Continuing Professional Development* (NMBA, 2016) identifies a CPD cycle for nurses/midwives that involves reviewing practice, identifying learning needs in alignment with registration and role requirements, planning and participating in relevant learning activities (Refer to ***Figure 3***). This cycle culminates in renewal of registration, and continues each year with ongoing consideration of requirements for professional obligations to maintain registration, and ongoing capacity, and capability building (NMBA, 2016). In addition, the value of CPD activities should be considered, and participation documented contemporaneously in a CPD journal or portfolio.

Figure 3: Continuing Professional Development (CPD) Cycle



Adapted from NMBA CPD Guidelines (NMBA, 2016)

Please note that annual reflection on learning and development needs, and participation in the CPD cycle identified in ***Figure 3*** is the responsibility of each individual nurse/midwife as per the NMBA (2016) CPD guidelines.

To maintain registration, nurses/midwives involved in any form of nursing/midwifery practice in Australia are required to participate in, and provide evidence of annual CPD relevant to the context of their practice commensurate with the minimum hours (20 hours) specified by the Nursing and Midwifery Board of Australia (NMBA, 2016). (Refer to Section 9.2: Professional Learning).

Furthermore, opportunities to foster development and/or maintain advanced clinical, leadership, management, education and research knowledge and skills should be offered to each nurse/midwife in line with service needs, the Generic Level Statements (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) for position classification, role responsibilities and individual PDP.

Moreover, CPD is about personal commitment. This requires recording the outcomes of individual learning and development, so questions can be asked such as: "What did I learn?" and "How do I plan to apply this learning?" rather than simply "What learning event did I experience?"

The expectation is that participation in CPD incorporates accountability; an active role in programs and other offerings; and documentation of individual application of the values and benefits of ongoing development from a personal, clinical, professional and organizational perspective (Simmonds, 2003).

Standards for CPD

Standards for CPD are supported as they apply to the individual, HHS/facility/directorate/service. Therefore, nurses/midwives should undertake CPD opportunities in line with individual, clinical, professional and organisational learning needs/goals as identified in their PDP or as negotiated.

As per the NMBA Registration Standard Continuing Professional Development, it is the responsibility of each nurse/midwife to participate in a minimum of 20 hours of CPD per year for respective professions (Refer to ***Section 9.2: Professional Learning***) and the identified NMBA Standard (NMBA, 2016a)

A lack of clarity about what counts as, and access to CPD have been raised as issues impacting on engagement in CPD activities, workplace culture and staff satisfaction (Katsikitis, Mcallister, Sharman, Raith, Faithfull-Byrne and Priaulx, 2013).

Standards for CPD

- Registration is dependent on annual compliance with the Registration Standard Continuing Professional Development (NMBA, 2016a).
- Individual CPD activities are undertaken to generate enhanced capacity, capability and professional and organisational learnings and are applied, as relevant to context of practice.
- Individual CPD records/portfolios are maintained contemporaneously for reflection, audit or investigation purposes for a minimum of five years (NMBA, 2016a; NMBA, 2016b).
- Organisational and professional CPD offerings are aligned to Department of Health, HHS/facility/directorate/service/work unit legislation and regulatory requirements, plans, frameworks, policies/procedures, business rules and service needs.
- Adequate infrastructure support and resources are allocated to sustain CPD programs, processes and evaluation against criteria.
- Organisational and professional CPD records of attendance and training resources are maintained for tracking, audit and compliance purposes for a minimum of five years (General Retention and Disposal Schedule, 2017).
- Targets for legislative and mandatory training compliance; targets for training related to introduction of new services/equipment, and the number/percentage of nursing/midwifery staff with post graduate awards in line with the Australian Qualifications Framework (Australian Qualifications Framework Council [AQFC], 2013) are determined and reported as per HHS/facility/directorate/service requirements.
- Organisational and professional CPD offerings are evaluated to maintain rigorous standards and determination of return on expectations (DETE, 2014).

Moreover, in many instances CPD is often only viewed as formal training, however CPD includes a wide range of activities (Refer to ***Appendix 2***). These examples offer an indication of the types of activities that can be undertaken under the universal term CPD that will contribute to achievement of learning outcomes (HCPC, 2017). While attending lectures, conferences and courses remains a key aspect of lifelong learning, it is important to realise that the majority of learning originates from experience in day-to-day practice (Health and Care Professions Council [HCPC], 2017).

As identified, while there is a vast array of activities couched as CPD in which nurses/midwives can engage, HHS/facility/directorate/service relevant processes and infrastructure need to be considered in respect to the nature and extent of CPD support and ability to achieve the predetermined standards within resource allocations. The nature, scope and investment in ongoing learning and development will directly influence the achievement of standards, staff expectations, and service outcomes. Moreover, while CPD is recognised internationally as a core element of the ongoing development and maintenance of professional expertise, it appears that it is effective only to the extent it is supported and implemented in practice with outcomes that can be measured (Daley, 2001; South African Qualifications Authority [SAQA], 2015; Morgan et al., 2008; Murphy and Calway, 2008). Therefore, to achieve desired outcomes and learning experiences CPD offered within the workplace should be diverse, multifaceted and supported by a robust theoretical framework that encourages active engagement of nurses/midwives in the context of practice, and evaluated against predetermined criteria (Katsikitis et al, 2013; Skees, 2010).

CPD is not just about attending courses and gaining qualifications. It also concerns the integration of learning, work, and knowledge attainment from broad experiences, both 'on and off the job', and gaining enhanced professional awareness to enrich the nurse/midwife's contribution to the workplace and quality service delivery (NMBA, 2016a; Skees, 2010).

8.1 Workplace Learning

As noted in the section above, workplace learning is considered a component of CPD. As such, the perspective offered by numerous authors is that working is interconnected with learning and accordingly, workplace learning is viewed as the informal and formal manner by which skills are upgraded and knowledge gained at one's place of work (Billett, 2016; Cacciattolo, 2015; Eraut, 2000).

This type of learning, which takes many shapes, is generally considered to be a learning intervention in the form of internal training (programs, training courses); and experience-based learning opportunities through preceptoring, coaching and mentoring (e.g. incidental; bedside; job rotation; consumer interactions) (Silverman, 2003). It also includes continuous learning where the work environment is focused on providing opportunities to learn new skills and knowledge through encouragement, access, and resources that foster accountability for self-directed learning (Eraut 2000; Silverman, 2003).

Consequently, diversity of opportunities within the workplace is significant in encouraging engagement and interactions with others in lifelong learning through workplace participation (Billet, 2004 and 2016). Additionally, numerous authors assert that an organisation's performance capability is directly related to the employee's ability to learn (Billett, 2001, 2004; 2016; Cleary, 2011; Matthews, 1999; Maxwell, 2014; Murphy and Calway, 2008; O'Connor, 2004; Schoonbeck and Henderson, 2011; Scott, 2015). Hence, how the individual accesses familiar and new workplace activities and interacts with more experienced colleagues and support systems also influences learning (Billet, 2004 and 2016; Maxwell, 2014; Schoonbeck and Henderson, 2011; Scott, 2015).

Accordingly, commitment by nurses/midwives is critical due to advancing technology, social change, increasing work demands and consumer expectations. These impacts influence the ability to fulfil workplace expectations, demonstrate professional standards and remain engaged in workplace learning to achieve best practice outcomes (Fox, 2013).

Focussed strategies by the employer are required in order to satisfy multi-generational engagement, ambition and desire to continue to learn and progress through an organisation to maximise staff retention. As such, it is important that teaching and learning strategies offered by the employer build capacity and capability and nurture engagement in a positive workplace culture to keep individuals excited about their work (Billet, 2016 and 2016; Schoonbeck and Henderson, 2011; Scott, 2015).

Organisational barriers requiring consideration in respect to fostering effective workplace learning include: perceptions of power and inequality; lack of trust; nature of the culture of learning in the work unit; access to opportunities; and the skill set of those providing the workplace learning offerings (Cacciattolo, 2015).

In today's health care context, nurses/midwives are faced with the reality that changing forms of employment, workforce skills and competencies required to perform in the workplace necessitate a commitment to continual periods of up-dating existing knowledge, re-directing old skills and acquiring new ones (Fox, 2013; Bridges et al, 2014; Cleary et al, 2011; Pool, Poell and Cate, 2012). As noted, such changes may be required multiple times in a nurse/midwife's working lifetime. Therefore, HHS/facility/directorate/service governance should incorporate nursing/midwifery educational strategies. Additionally, it is essential that Nurse/Midwifery Educators, in consultation with others, consider strategies to overcome individual resistance to continuing participation in more structured forms of learning (e.g. CPD) and workplace learning offerings to promote engagement in, and progression of lifelong learning (Cleary et al, 2011; Pool, Poell and Cate, 2012; Stella, 2012). While such strategies applied can be many and varied, one of the most effective ways to foster individual interest in learning is to align strategies to interest, need, relevance to role classification generic level expectations and practice context (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]). This can be achieved using learning pathways and focused career development in respect to short and long-term goals. The following ***Section 8.2: Career Development***, provides an overview of how lifelong learning and CPD, including workplace learning, can be applied to nursing and midwifery career progression.

8.2 Career Development

Career development is a lifelong process of complementing and managing learning, work-life balance and transitions to move towards a personally determined and evolving preferred future (MCEECDYA, 2014; McMahon, Patton and Tatham, 2002). Contemporary literature purports that individuals should be much more than passive recipients of a career process (Hall and Moss, 1998; MCEECDYA, 2014). As such, each individual should be responsive to the changing nature of work and the requirement for lifelong learning by proactively taking responsibility for the direction and evolution of their own career and career development.

The career development of a nurse or midwife is based on individual, professional and organisational imperatives (Conway and McMillan, 2012). The underpinning focus is the advancement of skills and knowledge that will enhance performance, meet community and organisational expectations and equip the individual for ongoing employment experiences (Conway and McMillan, 2012; MNHHS, 2014b; Queensland Health, 2018c). Consequently, career development is not a simple event or even a string of discrete activities. It is however, the synthesis of ongoing episodes, experiences, observations, and thoughtful analysis (MNHHS, 2015a).

Standards for Career Development

Nurses and midwives proactively participate in career development along a continuum of lifelong learning which is fostered and supported by the HHS/facility/directorate/service/work unit (Ross, Barr and Stevens, 2013; NMBA, 2016).

Standards for Career Development

- Individual career development activities undertaken to generate enhanced capacity, capability, clinical, professional and organisational learnings are applied as relevant within context of practice.
- Career development and succession management systems and processes are established, implemented and evaluated (Groves, 2007; Grundy, 2017; Moore, 2017).
- Clinical, professional and organisational career development offerings are aligned to Department of Health, HHS/facility/directorate/service/work unit strategic and operational objectives (AHRI, 2018).
- Timely coaching, preceptoring, mentoring, succession management and career development opportunities are offered to enhance and supplement individual and workforce development that predominantly occurs 'on-the-job' (Grundy, 2017; Moore, 2017; McIlveen, 2009; SA Health, 2014).
- Career development strategies are aligned to PDP, strategic/operational/work unit plans and clinical, professional and organisational learnings.
- The HHS/facility/directorate/service/work unit is responsible for providing career offerings and support to nurses/midwives that promotes engagement in a culture of lifelong learning and commitment to workplace performance (SA Health, 2014).

Whilst demonstration of Career Development Standards is necessary in progressing individual and professional advancement, this process should be aligned with achievement of applicable post graduate awards. Therefore, it is highly desirable that exploration of an appropriate program of study at a relevant Australian Qualification Framework (AQF) level for the nursing/midwifery classification or role being fulfilled is undertaken (AQFC, 2013) (Refer to ***Appendix 3: Recommended AQF Levels for Nursing/Midwifery Classifications***). As a component of CPD this will facilitate achievement of role expectations and promote graduate outcomes of the chosen program of study that are incorporated, and aligned to practice, and career pathway progression. Therefore, it is important that each nurse/midwife develops a portfolio of awards/qualifications and recognition of hours of learning (credits) that reflects contemporary knowledge and career advancement ability (OCNMO, 2014). A portfolio of CPD involvement including awards/qualifications is viewed as an essential part of any genuine lifelong learning which is transferable to different situations (Fox, 2013).

Opportunities to foster ongoing development, capacity and capability including where applicable, advancement of knowledge and skills for the nursing/midwifery classification should be offered, and supported by the employer in line with requisite role responsibilities and individual PDP. The focus for career development should initially align to the Generic Level Statements for the relevant Award classification (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) and role description. Support for this approach can be bolstered in the form of career pathways that enable the individual to identify, and acquire the requisite knowledge, skills, attributes and behaviours to meet specific role expectations, advance their practice and potentially progress to higher levels of education and employment.

8.2.1 Career Pathways

Career pathways are tools that provide clarity, direction and structure that facilitates career development and succession management (MNHHS, 2015a) (Refer to ***Section 12.6: Succession Management***) and optimise the scope of practice of the individual and their ability to effectively fulfil role expectations in the context of practice. The collective benefits of using career pathways include but are not limited to: continuity of performance; capacity and capability building; continuous practice improvement; creating prepared employees; and contribution to the profession (Jenkins and Spence, 2006).

To realise such benefits, career pathways should incorporate the five domains *(Direct Comprehensive Care; Support of Systems; Education; Research; Professional Leadership)* of the Generic Level Statements of the Award (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]), predicated on the five domains of the Strong Model of Advanced Practice (Ackerman, Norsen, Martin, Wiedrich and Kitzman, 1996 [adapted by Gardner and Duffield {2007 and 2016}]) and be developed for each classification Grade 1 Band 1 - Grade 13 Band 2 in order to clearly identify role expectations. Therefore, the intent of utilising a suite of Career Pathways is to:

- identify expectations of the Award (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) classification and a specific role
- assist with orientation to a new classification and/or role
- enable review of expectations of a classification or role especially after changes to awards; redesign; prolonged employment within the same role; and/or return to practice
- provide direction, and support to individuals for continuing professional development to meet standards
- assist with annual PDP expectations and reframing in situations where enhanced performance is required
- promote organisational systems and processes such as: succession management and mentoring frameworks/ strategies (MNHHS, 2017b).

The Office of the Chief Nursing and Midwifery Officer is leading the development of midwifery career pathways and classification structure. Future versions of the Framework and other supporting resources will reflect any amendments to the midwifery career pathways. In the interim current resources can be applied as relevant to support the midwifery profession.

Each individual utilising a Nursing and Midwifery Career Pathway should refer to the Australian Qualifications Framework levels (AQFC, 2013) (Refer to ***Appendix 3: Recommended AQF Levels for Nursing/Midwifery Classifications***) to determine the nature and standard of post graduate study that would assist to meet role expectations. Additionally, applicability of Advanced Standing or Recognition of Prior Learning (Refer to ***Section 13.2: Advanced Standing/Recognition of Prior Learning***) should be explored as a mechanism to reduce repetition of previous learnings when participating in any career development. Furthermore, application of a career pathway should occur in conjunction with Succession Management and Mentoring Frameworks/strategies (Refer to Section ***12.6: Succession Management*** and ***Section 12.5: Mentoring***) to promote organisational processes for identifying, selecting, and managing successors, and career planning (MNHHS, 2017b).

To assist in appreciation of career pathway application, Career Pathways for each classification of nurse/midwife Grade 1 Band 1 - Grade 13 Band 2 and activities for each broad classification and specific role have been devised to assist in achieving expectations (MNHHS, 2017b) (Refer to OCNMO Professional Capability site ***https://qheps.health.qld.gov.au/nmoq/professional-capability/education***).

In undertaking this innovative change, the originators acknowledge that career pathways are not necessarily linear but provide a guide to the nature and extent of learning required to achieve classification and role expectations (MNHHS, 2017b and 2017c). This initiative is the first known attempt in Australia to align

an industrial instrument (the *Award*) with a career pathway, the AQF, role descriptions and organisational and professional requirements.

Moreover, it is acknowledged that while a career pathway facilitates individual development in respect to career choice, the pathway can also be tailored and applied to provide a standardised indication of nursing/midwifery classification and role expectations, and to evaluate achievement of these expectations. In addition, individualised context specific learning pathways can be used to further assist nursing/midwifery staff in aligning their learning development needs with a career structure and clinical, professional and organisational learning.

8.2.2 Learning Pathways

In planning a lifelong learning journey each nurse/midwife should consider using a learning pathway to provide direction to their learning and development needs. This approach provides a meaningful perspective of moving through, and between different education and training options which may consist of further study, job promotion or employment (or a combination of these) (Federation University, 2014; Rafferty, Xyrichis and Caldwell, 2015). Furthermore, as previously identified workplace learning and an individual learning pathway should align to the individual's goals for career progression, PDP, and where applicable career structure. Additionally, an individualised learning pathway provides guidance to achievement of competencies and academic awards that involves participation in a structured and sequenced learning process which offers relevant learning experiences (Jenkins and Spence, 2006; MNHHS, 2017b; Rafferty, Xyrichis and Caldwell, 2015).

Therefore, a learning pathway should be flexible and can be achieved using a combination of strategies, for example 'on-the-job learning', 'off-the-job learning', and recognition of prior learning (i.e. the skills, knowledge and experience already gained) (Refer to ***Section 13.2: Advanced Standing/Recognition of Prior Learning***). A pathway also provides a visual representation of learning content to facilitate achievement of attributes and competence. In determining a learning pathway entry points, qualifications for a role and their general alignment with the AQF requires careful deliberation (AQFC, 2013). Moreover, in circumstances where additional knowledge and skills are considered obligatory in effective role application, the profession, organisation and health consumers would benefit by the individual being encouraged to enrol in a HES program leading to an AQF qualification (AQFC, 2013; Federation University, 2014; Rafferty, Xyrichis and Caldwell, 2015).

Furthermore, a learning pathway can also be viewed as an ideal sequence of learning activities that energises an employee to enhanced capacity and capability in their job in the shortest possible time. In this situation, a learning pathway is created for the role performed (Jenkins and Spence, 2006; MNHHS, 2017b; Rafferty, Xyrichis and Caldwell, 2015).

Additionally, a learning pathway may take the form of a Work Unit Development Map (Refer to ***Section 10.3: Work Unit Development Map***) that exemplifies key elements of learning required to assist with transition to a role, consolidation of knowledge, skills, capacity building, and path for individual learning aligned to clinical, professional and organisational requirements. Therefore, as previously identified a learning pathway is often aligned to a career structure and a formalised career pathway and/or an individual's own goals for career progression. By considering learning as a complete process rather than a single event, a learning pathway linked to a career pathway enables both the employer and employee to find new ways to reduce duplication of effort, wasted time and variability in training thus leading to improved results and reduced costs (Williams and Rosenbaum, 2004; Rafferty, Xyrichis and Caldwell, 2015).

Accordingly, a learning pathway may be short term, perhaps something that spans just a few days or a week, or conversely take several years to complete (e.g. higher education and training culminating in an award/qualification). Irrespective of intent a learning pathway that has 'real-world' relevance assists in meeting the personal needs of the learner from a clinical,

professional, organisational and context perspective. As such, learning pathways also support individuals to become more engaged, motivated and academically successful in meeting the challenges of rapidly changing needs and priorities for knowledge and skill development, including up-skilling and lifelong learning (Williams and Rosenbaum, 2004; Rafferty, Xyrichis and Caldwell, 2015) (Refer to ***Section 7: Lifelong Learning***).

A robust culture of learning is vital to the successful application of both career and learning pathways in cultivating opportunities, supporting learning, and enabling professional growth and development in the workplace.

Furthermore, to realise the benefits of lifelong learning and CPD (***Appendix 2***) every nurse/midwife is accountable for demonstrating the requisite responsibilities for each of the five domains of the Award Generic Level Statements (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) for the classification, and for participating in critical debate, collegiality and interactive relationships with academic and research communities in accordance with role expectations.

Standards for Learning Pathways

Learning linked to a learning and/or career pathway enables both the employer and employee to consider learning as a comprehensive process, and explore new ways to reduce duplication of effort, and variability in training leading to improved return on expectations and satisfaction.

Standards for Learning Pathways

- Each nurse/midwife is responsible for demonstrating how the application of an individual learning pathway facilitates learning and development and/or succession management through their negotiated PDP which incorporates career goals (NMBA, 2016a and b; SA Health, 2014).
- The HHS/facility/directorate/service is responsible for cultivating opportunities for professional growth through the provision of a suite of resources aligned to the career structure, and career pathways to encourage individual nurses/midwives to initiate and facilitate achievement of goals and career progression (Matthews, 2012; SA Health, 2014).
- Each nurse/midwife is responsible for demonstrating requisite role requirements aligned to the five domains of the Award Generic Level Statements for the classification and associated learning needs (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).
- Line managers, Nurse/Midwifery Educators and others are accountable for promoting and supporting employee use of learning pathways though PDP, access to resources and application of strategies that foster development, and a culture of lifelong learning (Department of Health, 2013; Queensland Health, 2017b; SA Health, 2014).
- Nurses/midwives undertaking development in areas of specialty practice use a contextualised learning pathway to identify learning requirements, milestones and assessment components as negotiated within individual PDP.
- Newly graduated nurses/midwives use learning pathways to accelerate transition to the role, profession, and workplace expectations.

Figure 4 (page 27) provides a schematic representation of how ongoing professional development and advancement of a culture of learning for nurses/midwives via a progressive learning pathway can be applied to support any classification of nurse/midwife throughout their work life. Each component of the representation identifies strategies able to be used to provide learning and development opportunities in a coherent and structured format. If applied effectively these will assist in; supporting, developing, attracting, and building workforce and professional capacity, and retention of skilled and committed nurses/midwives. The representation also shows direction for planning, design, implementation and evaluation of educational opportunities for development. Furthermore, it illustrates that each classification of nurse/midwife should be engaged in lifelong learning (CPD activities) to progress practice in the workplace, irrespective of individual aspirations for career development, and succession.

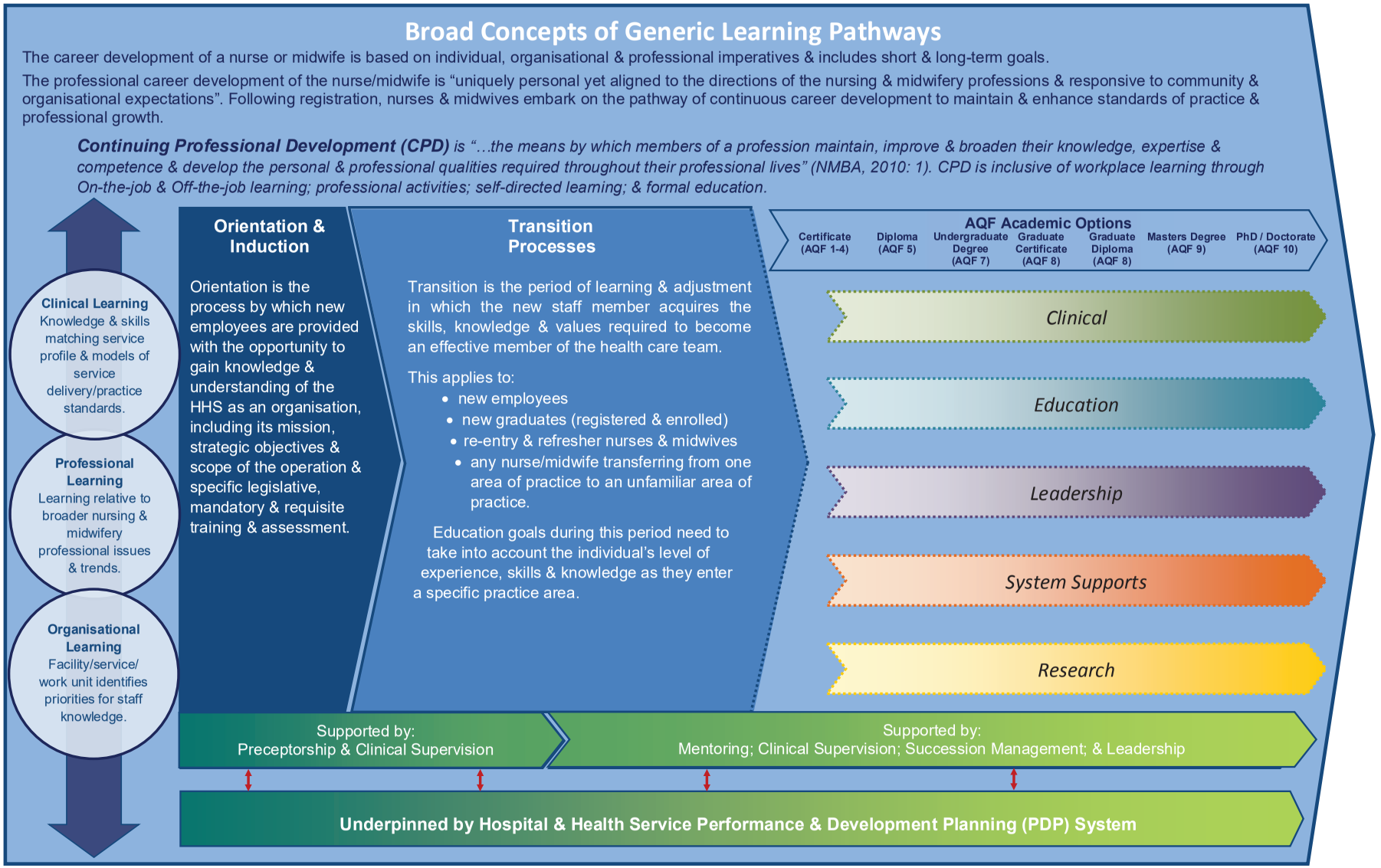
Figure 5 (page 28) offers a schematic example of a specific learning pathway. All of the components depicted in this pathway are supporting processes that guide the individual nurse/midwife's progression to another aspired classification. Included are options for formal education leading to an award. ***Figure 5*** provides the perspective of linear and non-linear progression examples including but not limited to: Grade 5 nurse/midwife to a Grade 6; Grade 5 to a Grade 7 or nurse practitioner candidate; Grade 6 to a Grade 7.

To facilitate accelerated transition, an individual learning pathway should be linked to a Work Unit Development Map (Refer to ***Section 10.3: Work Unit Development Maps***) which in diagrammatic form summarises the key clinical, professional and organisational learnings required for a specific role within a particular work unit. The *Work Unit Development Map* can also be individualised to address discrete and work unit learning needs. Each time a nurse/midwife changes role or work unit throughout their career a learning pathway and/or a Work Unit Development Map can be used as a resource to assist with ongoing development and capacity building.

It is recognised that in a rapidly changing healthcare environment, the nursing/midwifery workforce must continually update knowledge and skills to enable effective performance in the workplace (Booker, Turbutt, and Fox, 2016). Additionally, there is the expectation that this workforce is adaptable, flexible and skilled to build capacity and sustain quality health care (Booker, Turbutt, and Fox, 2016; MNHHS, 2015c; Queensland Health, 2011). This requires nurses and midwives to source 'on and off the job' CPD opportunities. However, when not available in the workplace, or within an HHS, capacity building and up-skilling CPD requirements can be sourced from external education providers e.g. HES partners, industrial bodies, professional bodies, and speciality interest groups (MNHHS, 2015c; Queensland Health, 2011).

All tenets of Career Development (Refer to ***Sections 8.2: Career Development***, ***8.2.2: Learning Pathways***) are transferable and should be contextualised to guide the nurse/midwife's journey in attaining specialist knowledge and skills and optimising their 'full scope' of practice. However, in providing guidance towards specialisation additional considerations are required to actualise optimal scope of practice, capacity and outcomes.

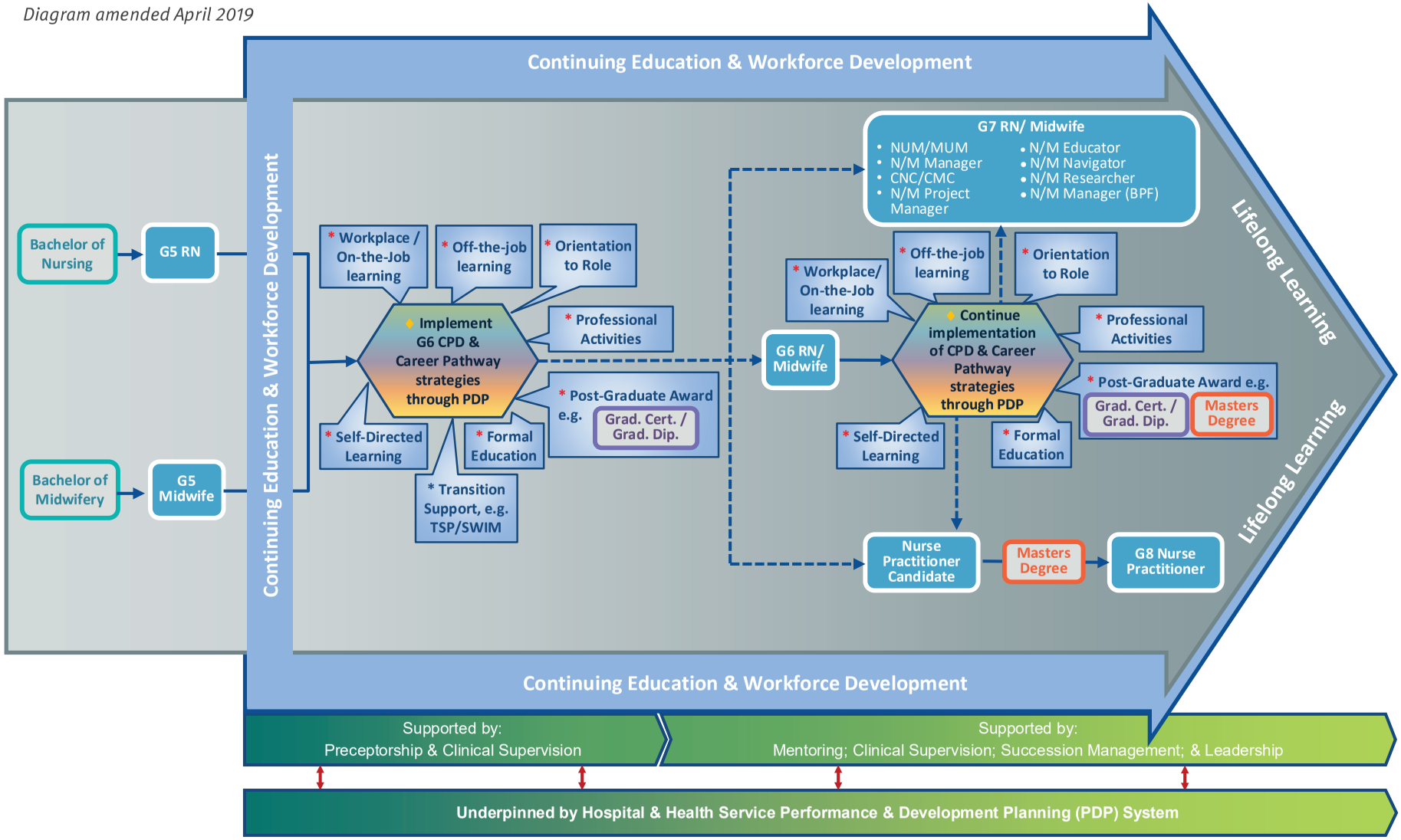
Figure 4: Broad Concepts of Generic Learning Pathways



Model adapted from MNHHS (2015c)

Figure 5: Learning Pathway – Example Grade 5 RN/Midwife entering the workforce and progression via linear and non-linear means

Diagram amended April 2019



N.B. **This is an example only & CPD Activities (e.g. Post-Graduate Awards) may be modified to fulfil individual Learning Pathway & role requirements.**

* **Refer to *Appendix 2: Examples of CPD Activities* for suggestions for Workplace Learning; Professional Activities; Self-directed Learning & Formal Education activities & *Award – Generic Level Statements*.**

♦ **Application of each of the *Award – Generic Level Statement (2015)* domains must occur in respect to role consolidation, CPD activities & career progression requirements, e.g.** *Clinical* *Education* *Leadership* *System Supports* *Research*

8.2.3 Nursing Specialisation Pathways

New roles and titles are continuously being created in nursing/midwifery in an attempt to optimise practice, and in response to the unprecedented rises in healthcare demand (Daly and Carnwell, 2003; Gray, 2016; White et al., 2008). At times this occurs without fulsome exploration of differences between the two professions, existing roles; mapping of boundaries of practice; levels of clinical autonomy; and preparation to fulfil these roles (White et al., 2008). This results in reported: role confusion, conflict and uncertainty regarding requirements and scope (Martin-Misener and Bryant-Lukosius, 2014; White et al., 2008). As such, individual achievement of *'optimal scope of practice'* is dependent on risk assessment, alignment to professional, regulatory and legislative frameworks, role examination, context of practice and models of care (Booker, Turbutt and Fox, 2016; CRNNS, 2015; OCNMO, 2013a and b).

The NMBA ***'A national framework for the development of decision-making tools for nursing and midwifery practice'*** provides the nurse/midwife with foundational principles for decision-making related to both professional and individual scope of practice optimisation (NMBA, 2007; OCNMO, 2013a). To advance practice to optimal scope, the individual must demonstrate professional knowledge, clinical reasoning and judgement, and higher order skills and behaviours requisite to the full requirements of a role (NMBA, 2016e). Whilst, from a regulatory perspective, there is ability to advance enrolled nurses and all registered nurse/midwife practice (skills and knowledge) (NMBA, 2006, 2007, 2016c, 2016d and 2018d), Gardner, Duffield and Doubrovsky (2017) contest that the Nurse Practitioner (Nurse Grade 8) role demonstrates the highest level of advanced practice activity (particularly direct clinical care). This occurs across all domains of the modified Strong Model of Advanced Practice Role Delineation tool which aligns to the Generic Level Statement domains of the *Award* (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]). The other Nurse Grade 7 roles are similarly identified as advanced practice roles however; variance was noted between domains (Gardner et al., 2017).

Nurse Grade 6 and Grade 5 roles scored highest in the direct clinical care domain with a lower level noted in Grade 5 (Gardner et al., 2017).

Consequently, these findings indicate that when support is required for development of specialist knowledge and skills the learning pathway negotiated should incorporate not only a focus on direct clinical care but inclusion of activities. This will enhance requisite knowledge and skills across all 5 Domains of the Award (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) relevant to role requirements and context of the specialty area of practice (Gardner et al., 2017). This approach is particularly important as specialisation in nursing is the separation of more general knowledge and skills along a logical pathway to focus on a specific area of practice (Booker, Turbutt, Fox, 2016). As such, specialisation in nursing involves a narrowing and deepening of focus (e.g. Perioperative); or recombination of aspects of different areas of knowledge and practice competencies with a simultaneous narrowing and deepening of focus (e.g. Rehabilitation). For example, Oncology, Cardiology, and Neurology are specialties, each with a distinctly narrow, but deep knowledge focus. Whereas, Cardiac Rehabilitation is an example of combining multiple areas of knowledge (Oncology, Cardiology and Rehabilitation) to create a specialty with a depth of focus that acknowledges the study of relationships among explicit experiences.

Given the practice of nursing/midwifery is dynamic and evolves continually in response to scientific, technological and professional advancements the need to support colleagues gain focused speciality knowledge, and the nature of support provided is fundamental to realise expected outcomes and keep pace with consumer and health care demands (White et al., 2008). Furthermore, review of the individual's scope of practice is also essential to ensure continuity and enhancement of performance, capability to meet the requirements of existing and future healthcare challenges, and to support improved outcomes in respect to the speciality area of practice. Support processes to facilitate specialty knowledge and skill acquisition can be achieved by accessing diverse CPD activities within and

external to the workplace (e.g. CPD upskilling workshops [e.g. ECG, Tracheostomy Care]; Post Graduate Certificate; Diploma, Masters (AFQ, 2013)).

Thus, it is important to offer a wide variety of established CPD education and training programs delivered onsite within the HHS/facility/directorate/service/work unit, where and when necessary to support staff engagement in mandatory and requisite learning and speciality practice needs related to their context of practice. As such, this CPD engagement is typically based on individual, clinical, professional and organisational learning imperatives as identified within the annual PDP, or as negotiated according to arising needs (MNHHS, 2015c; Queensland Health, 2011).

9. Clinical, Professional and Organisational Learning

As previously identified, to promote and support engagement of a nurse/midwife in lifelong learning and CPD activities, a culture that values learning in the workplace, provision of strategies that foster integration and culmination of learning within and/or across practice domains are imperative.

Additionally, context of practice is important when considering workplace learning in healthcare, and while it does not set the course of action or determine experience, it does identify the conditions in which problems and situations arise, and subsequent learning requirements (MNHHS, 2015c; Queensland Health, 2011). Intrinsically, nursing and midwifery education services facilitate the integration and culmination of learning that occurs within and across the context of practice. Therefore, to address the majority of workplace education needs, learning can be broadly aligned to clinical, professional and organisational requirements supported by principles of adult learning within a lifelong learning paradigm (MNHHS, 2015c; Queensland Health, 2011).

Consequently, the three (3) spheres of clinical, professional and organisational learning can be used as a scaffold to provide Nurse/Midwifery Educators, and others a reliable platform on which to base workplace CPD offerings that are relevant to the context of practice and the individual in building workforce capacity and capability.

Standards for Clinical, Professional and Organisational Learning

Nurses and midwives are supported to undertake clinical, professional and organisational learning opportunities in order to meet the changes in the healthcare industry and build work force capacity and capability (MNHHS, 2015c; Queensland Health, 2011).

Standards for Clinical, Professional and Organisational Learning

- Clinical, professional and organisational education and training are viewed as core functions of the HHS/facility/directorate/service and nursing/midwifery classifications, explicitly in respect to resourcing, planning, managing and evaluation (MNHHS, 2015c).
- Nurses/midwives proactively adopt and apply regulatory frameworks, professional standards, codes of practice, and engage in CPD activities to enrich the skills and knowledge of the nursing/midwifery workforce (MNHHS, 2015c).
- Nurses/midwives work within legislation, scope of practice, endorsed standards and competencies of relevant regulatory and professional bodies, Department of Health/HHS/facility/directorate/service/work unit procedures, policies and business rules (NMBA, 2007; MNHHS, 2015c; Queensland Health, 2011).
- Nurses/midwives are offered relevant CPD, up-skilling and capacity building opportunities to enable demonstration of competence requisite role expectations, and career progression (succession management) (MNHHS, 2015c; Queensland Health, 2011).
- Organisational learning which encompasses the knowledge, skills and abilities required to function effectively in a role to achieve organisational aims and objectives, and to build capacity to meet current and future workforce demands is supported as per BPF (OCNMO, 2016) and Award provisions (MNHHS, 2015; Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]; Queensland Health, 2011).
- The HHS/organisation/facility supports the development of practice, and capacity building as continuous processes of improvement which contribute to a culture of learning and inquiry (MNHHS, 2015c; NMBA, 2018a and b; Queensland Health, 2011).

9.1 Clinical Learning

Clinical learning relates to requisite knowledge, skills, and attributes specified by an HHS/facility/directorate/service as being essential to enable nursing/midwifery staff to demonstrate acceptable standards of practice in the delivery of person-centred care to achieve best practice outcomes. The *Service Capability* (Queensland Health, 2016d) or delineation (e.g. rural, community), clinical work unit service profiles (OCNMO, 2016), model/s of service delivery and specific '*Work Unit Development Maps*' (Refer to ***Section 10.3: Work Unit Development Map***) provide mechanisms to assist in the identification of requisite clinical skills for a specific work unit.

Professional nursing and midwifery practice in the current complex, and rapidly changing environment necessitates that clinical education and training occur within a framework of continuous lifelong learning across a broad continuum from professional pre-entry level to experienced skilled clinician (where applicable advanced and expanded practice [RN/RM only]) (MNHHS, 2015c; Queensland Health, 2011). Maximising learning through lived experience in the clinical setting is considered essential for nurses/midwives. This results in knowledge being indexed and organised in ways that are purposeful by providing nurses/midwives the opportunity to develop increasingly mature approximations of procedures required to be successful in activities through the process of testing and modifying actions and standards (Billett, 2004 and 2016; Davis, 2015; Fox, 2013; Tiwaken, Caranto and David, 2015). Consequently, active engagement in workplace learning is particularly useful for the transfer of knowledge to other circumstances and assists with adaption of new stimuli to existing knowledge and pathways to specialisation. Accordingly, clinical learning comprises activities performed by nurses/midwives which impact on clinical outcomes. These include (but are not limited to):

- Technical skills e.g. invasive procedures, fundamental nursing skills e.g. clinical assessment, activities of daily living, interpretation of data, nursing patient care
- Non-technical skills e.g. communication, team interaction
- Cognitive skills e.g. decision-making, clinical reasoning, problem solving, critical thinking (Baraz, Memarian and Vanaki, 2015; Rennie, 2009).

Therefore, every action, behaviour and decision where the consumer is the motivation could be considered as a clinical skill. Intrinsically clinical learning promotes the acquisition of clinical knowledge, skills and demonstration of best practice in the clinical workplace. The intent is to build nursing/midwifery capacity and capability to enable performance to each individual's full scope of practice, not to disempower competent and experienced staff (College of Registered Nurses of Nova Scotia [CRNNS], 2015; Nelson et al., 2014).

In the workplace environment, students, nurses/midwives attain the clinical skills and requisite knowledge that enable the application of theoretical concepts to clinical practice. Moreover, as a regulated health professional every enrolled nurse (EN), registered nurse (RN), midwife (RM), nurse practitioner (NP) is responsible and accountable to the NMBA (NMBA, 2006, 2014, 2016c, 2016d and 2017; NMBA 2018b and 2018d) to practise in accordance with registration standards. This occurs by the NMBA:

> *... developing registration standards, professional codes, guidelines and standards for practice which together establish the requirements for the professional and safe practice of nurses and midwives in Australia* (NMBA, 2018c: p.1).

As such, the NMBA Standards for Practice for ENs, RNs, NPs and the Competency Standards for Midwives (*Midwife Standards of Practice effective 1st October 2018*) are the core standards expected regardless of context of practice (NMBA, 2006, 2014, 2016c, 2016d, 2017 and 2018d). These indicate the expectations of a nurse/midwife in relation to accountability, delegation and supervision (i.e. managerial supervision, professional supervision and clinically focused supervision).

The NMBA Standards for Practice/Competency Standards are:

- *NMBA Enrolled Nurse Standards for Practice* (NMBA, 2016c)
- *NMBA Registered Nurse Standards for Practice* (NMBA, 2016d)
- *NMBA National Competency Standards for the Midwife* (to be rescinded 1st October 2018) (NMBA, 2006)
- *NMBA Midwife Standards for Practice* (effective as of 1st October 2018) (NMBA, 2018d)
- NMBA Nurse Practitioner Standards for Practice (NMBA, 2014)

Throughout one's nursing/midwifery work life a minimum level of capacity and capability must be demonstrated as reflected by National Standards (ACHS, 2012); and professional nursing organisations, e.g. the Australian Nursing and Midwifery Federation (ANMF), Australian College of Critical Care Nurses (ACCCN), Australian College of Operating Room Nurses (ACORN), International Confederation of Midwives (ICM), and Australian College of Midwives (ACM).

***N.B.** The ICM as endorsed by NMBA specifies the competency standards for the midwife as educated and competent from graduation.*

- Specialty practice standards examples include but are not limited to:
  - *Australian College of Operating Room Nurses (ACORN) Standards for Perioperative Nursing in Australia* - (ACORN, 2016).
  - *Australian College of Critical Care Nurses (ACCCN) Standards* - (ACCCN, 2015).
  - *Australian College of Mental Health Nurses (ACMHN) Standards of Practice in Mental Health Nursing* - (ACMHN, 2010).

***N.B.** Specialty standards do not replace the NMBA Standards for Practice/ Competency Standards, which are the minimum standards for practice and registration* (NMBA, 2006, 2014, 2016c, 2016d, 2017 and 2018d).

Therefore, the importance of *NMBA Standards for Practice/Competency Standards* should not be underestimated or observed in isolation in practice. Additionally, NMBA codes and guidelines must also be used to inform the development of the scope of practice aspirations and behaviours of nurses/midwives (NMBA, 2006, 2007, 2014, 2016c and d, 2018a,b and d). As such, practice and professional standards make explicit that the purpose of professional learning is skills, practices, and dispositions needed to foster safety, an ever developing capacity and ongoing learning.

9.2 Professional Learning

Ongoing self-development of a nurse/midwife is primarily based on professional, individual and personal goals. In respect to CPD associated with professional learning the nurse/midwife engages in teaching and learning activities relative to broad professional issues and trends. Examples include but are not limited to: resolving ethical issues relating to practice; participating in professional group activities; considering professional codes, guidelines and ethical practice boundaries, and reflecting on how the profession participates in shaping state and national policy development (MNHHS, 2015c; Queensland Health, 2011).

CPD associated with professional learning in the context of the *Framework* reinforces the premise of enhancing knowledge, skills, and application to improve individual professional practice and collective professional effectiveness as measured by the nature of engagement and learning outcomes.

Incorporation and application of the relevant *NMBA Codes, Guidelines and Frameworks* is essential to optimise professional practice for each nurse/midwife.

In addition, there are standards that support the expected level of professional practice such as:

- *International Council of Nurses (ICN) Code of Ethics for Nurses* - (ICN, 2012)
- International Confederation of Midwives (ICM) Code of Ethics for Midwives - (ICM, 2014)
- *NMBA Code of Conduct for Midwives* - (NMBA, 2018a)
- *NMBA Code of Conduct for Nurses* - (NMBA, 2018b)
- *NMBA Framework for Assessing Standards for Practice for Registered Nurses, Enrolled Nurses and Midwives* - (NMBA, 2007)
- *NMBA Registration Standard: Continuing Professional Development* - (NMBA, 2016a).

Nurses/midwives who are committed to lifelong learning have a responsibility to share their skills and knowledge with colleagues and students, participate actively in ongoing professional development and contribute to the development of others through teaching and role modelling (Rischel, 2013).

The NMBA Registration Standard: Continuing Professional Development (NMBA, 2016a) and *Principle 5* of the NMBA Codes of Conduct for Nurses and NMBA Code of Conduct for Midwives (NMBA 2018a; 2018b) outline the responsibility of the nurse/midwife to participate in ongoing professional development of self and others. To maintain NMBA registration nurses/midwives are required to participate in a minimum of 20 hours of CPD annually relevant to their respective context of professional practice (NMBA, 2016a) (Refer to Section 8: Continuing Professional Development). The requirements for Nurse Practitioners, RNs/Midwives with scheduled medicines endorsement, and notation as an eligible midwife are an additional 10 hours CPD (NMBA, 2016a). Those holding dual registration e.g. EN/RN; RN/RM are required to undertake CPD for each registration (refer to NMBA Continuing Professional Development Fact sheet). Any professional development activity undertaken is recorded and supported through the PDP process and documented, e.g. professional portfolio. The portfolio of evidence of engagement in CPD is required to be maintained for five years for potential registration audit (NMBA, 2016a).

A performance and development culture embedded with a self-assessment process provides the opportunity to engage nurses/midwives in professional learning. Moreover, significant benefits are maximised through the provision of effective professional learning to address areas for improvement in professional practice. Professional learning can be promoted through a casual piece of advice from a colleague and one's own reading and/or through attendance at an international conference and exposure to the ideas of a globally recognised educational expert. It can also relate to: promoting professional awareness (e.g. maintaining knowledge of professional standards and codes and applying this to practice; briefing about a new policy or initiatives; and application of professional learning into the work unit context), developing skills and embedding and refining new practices (Cole, 2012). Whilst professional learning should address individual requirements, this needs to occur within the context of the professional awareness and promotion of the health facility's overall priorities, and improvement strategies (Cole, 2012).

To foster best practice outcomes from professional learning, it is essential that leaders collaborate with staff to articulate the types of improvements required to achieve agreed goals/expectations and develop a common language for describing good professional practices (Elmore, 2000; Stoll, 2004). Engaging with staff in professional discourse, drawing on external ideas, and research to encourage enquiry, reflection and inform organisational, work unit, professional, and individual actions aligned with discussion about strategies for desired outcomes are indicators of effective leadership.

Moreover, an effective leader facilitates opportunities for staff to learn from each other, provides access to specialised knowledge; and models lifelong learning in their own practice (Elmore, 2000; Stoll, 2004). Additionally, they recognise their own transience and therefore invest in succession management for the future.

A successful nurse/midwifery leader will also continuously evaluate the impact of professional learning based on the effect it has on achievements and outcomes (Elmore, 2000; Stoll, 2004). As such, a collective effort between leaders and staff is fundamental in achieving professional practice standards and best practice outcomes.

By leaders and others fostering governance and an environment that promotes individual, professional learning, growth and training opportunities staff are more likely to view the organisation as supportive and committed to them as an individual. As such, they will typically reciprocate with increased organisational commitment and contextual performance (Booker, 2011).

9.3 Organisational Learning

An organisation is a collective, with individuals and work units undertaking varying roles that involve different perspectives and values, passing information through their own filters, with connection often via ineffectual information channels. Individual members are continually engaged in attempting to know the organisation, and themselves in the context of the organisation. Therefore, the intent of organisational learning driven by the context of the workplace is to engage and motivate staff and organisations for positive growth (AHRI, 2015). Health sector organisations are faced with competitive, technology and economic pressures; therefore, their adaptability requires learning by the individual, team and organisation at a continual and rapid pace (AHRI, 2015).

Organisational learning outcomes are dependent on acquisition and application of new knowledge and skills and developing innovative strategies. However, the effectiveness of their learning is dependent on workplace culture, interpersonal interactions and views on the value of learning (Scott, 2015).

The following three (3) broad considerations are essential for organisational learning and adaptability:

- a supportive learning environment;
- concrete learning processes and practices;
- leadership behaviour that provides reinforcement (Garvin, Edmondson and Gino, 2008).

Organisational learning is strongly influenced by the behaviour of leaders. As such, when leaders actively question and listen to employees this prompts dialogue and debate, and employees feel encouraged to learn. If leaders signal the importance of spending time on problem identification, knowledge transfer, and reflective practice these activities are likely to flourish within the organisation (Booker, 2011; Garvin, Edmondson and Gino, 2008). When leaders demonstrate through their own behaviour a willingness to entertain and contemplate alternative points of view, employees feel encouraged to offer new ideas and options (Booker, 2011; Senge, 1990). When learning is embedded, an organisation continually expands its capacity to create its own future by being committed to encouraging staff to develop themselves. Furthermore, optimum individual and team functioning can be progressed through organisational learning (Schoonbeek and Henderson, 2014).

As such, an organisation's capacity for deliberate transformation of its own values, philosophy, strategic direction and expectations to staff facilitates the individual's ability to appreciate and transform their engagement and learnings. Organisational learning approached from a foundational perspective promotes inquiry, innovation, quality and research initiatives, as well as ability to review practices and self-correct previous experiences (Mulford and Silins, 2010). This approach supports individual development and has the ability to generate changes in systems, engagement and culture to realise desired outcomes.

Therefore, the benefits of cultivating organisational learning for nursing/midwifery staff include (but are not limited to):

- Improved consumer outcomes through enhanced ability to achieve service delivery requirements.
- The recruitment and retention of nurses and midwives.
- Provision of a safe, competent nursing and midwifery workforce.
- Clinical capacity building, capability and sustainability of nursing and midwifery services.
- An increase in the levels of nursing/midwifery satisfaction in relation to access to workplace education and training.
- Increased numbers of nurses and midwives with post graduate qualifications with ability to translate and apply learnings to the workplace.
- Improved sense of control over work environment, thereby decreasing job stress and increasing well-being as a result of working in a culture in which learning is valued and mistakes are tolerated (OCNMO, 2014; Queensland Health, 2017b).

In the Framework, organisational learning relates to the knowledge and skills required by nurses/midwives to function effectively in their roles to achieve specific aims and expectations. It includes, but is not limited to, any learning associated with the organisation's direction or needs. At the fundamental level, this can include education on the *Code of Conduct for the Queensland Public Service* (Queensland Government, 2011) or the performance management system of the organisation. This sphere of learning also includes cognitive and psychomotor skills required to meet specific position functions, for example, managers will require skills in cost centre and human resource management processes (OCNMO, 2017).

To effectively achieve expectations a nurse/midwife must appreciate the principles of clinical, professional, and organisational learning relevant to role and Generic Level Statement responsibilities (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]). As such, a structured approach in the form of orientation and transition support should occur each time a nurse/midwife changes their place of work, role, and/or classification.

10. Orientation and Role Transition Support Processes

The main purpose of orientation and transition support processes is to prepare new and/or transferring (e.g. moving from another work unit or internal HHS facility) nurses/midwives to optimise their integration, and thus their performance within the organisation. This process of transition encompassing an orientation program is not a singular or independent event, but rather an ongoing, and evolving activity which should be individualised to optimise capability and competence as per role responsibilities.

10.1 Orientation and Induction

Orientation is the process by which new employees are provided with the opportunity to gain knowledge and appreciation of the HHS, including its mission, strategic objectives and scope of the health service comprising facilities, services and specific legislative, mandatory and requisite training and assessments (MNHHS, 2014). During orientation, nurses/midwives are informed about expectations, policies and protocols of the Department of Health/HHS/facility/directorate/ service/work unit.

Orientation is a coordinated process and at each stage of the contact, new colleagues transferring need different information, assistance, and varying forms of relevant support.

A core goal of any orientation is to assist new starters to comprehend the physical and digital environment: by them gaining the ability to navigate systems and resources; and be aware of how to seek support relevant to their learning needs. It is important that the concepts of self-management, and self-responsibility are promoted, and engagement during orientation supports a sense of belonging and identity (Dweck, Walton and Cohen, 2014).

When new staff members join an organisation, a distinction is often made between their orientation and induction to the new work environment. The orientation of new staff is usually seen as comprising a short one-off briefing session and the provision of basic information, to acquaint the individual with the organisation, for example in the form of an information resource such as a manual or kit which can be used for both new or transferring employees (Flinders University, n.d.).

Moreover, induction is the process of informing the new employees about practices, policies, and purposes of the organisation; socialising them to the organisation/work place environment, values and culture and professional expectations. It also determines that competency and confidence in the area of practice is measured to recognise the level of experience and capability in the context of practice. Often the terms orientation and induction are blurred and one is used to depict all aspects of assisting new and transferring employees to transition into a new workplace, role or area of responsibility (Dweck, Walton and Cohen, 2014).

Irrespective of terminology, classification, role or conditions of employment, effective induction and orientation are essential in: supporting successful integration; appreciating culture and values of the organisation; providing fundamental information; clarifying role purpose; minimising transition and supervision processes and potentially attracting and retaining an engaged staff member.

As such, orientation/induction are viewed as essential human resource management strategies that can influence the employee's subsequent attitudes towards the HHS/facility/directorate/service /work unit. Both strategies should be welcoming and support new employees or transferred staff to feel safe, appreciated and positive about the new workplace, values and expectations, and ultimately facilitate service effectiveness and efficiency (Rush, Adamack, Gordon, Janke, and Ghement, (2013).

In general Orientation/Induction comprises but is not limited to:

- General HHS Orientation (HHS information including legislative, mandatory, organisational training and assessment)
- Nursing and Midwifery Orientation (mandatory clinical and professional requisite requirements)
- Division/Service/Program and/or Work Unit Induction (specific requirements and requisite knowledge and skills) with planning commencing to address individual learning and additional transition support processes. This includes the application of a Work Unit Development Map to support effective and timely transition to the work unit) (Refer to ***Section 10.3: Work Unit Development Map***) (MNHHS, 2015c; Queensland Health, 2011).
- Orientation to the classification or role to distinguish specific responsibilities and role transition activities e.g. use of career pathways (Refer to ***Section 8.2.1: Career Pathways***) and/or provide clarity, direction and structure that facilitates career development, succession management and optimise the individual's scope of practice underpinned by PDP processes.

Orientation/Induction is a deliberate organisational strategy to welcome and integrate employees into the facility/directorate/service and as such, incorporates numerous benefits and intentions including:

- Reduction of commencement costs related to less duplication of effort and time relevant program content.
- Improved learning which may be otherwise compromised by new starter anxiety.
- Demonstration of staff value and potential enhanced retention through the provision of relevant, timely learnings within programs.
- Enhanced appreciation of the organisational values, attitudes and expectations to support the employee clarity and streamline transition into the facility/directorate/service.

Standards for Orientation/Induction

Facilities/directorates/services/work units deliver orientation programs that are congruent with orientation policies/procedures, and reflect the strategic direction, and operational requirements.

Standards for Orientation/Induction

- Orientation/Induction processes are included as core activities in all relevant strategic/operational/service delivery planning documents (MNHHS, 2015c; Queensland Health, 2011).
- Adequate nursing and midwifery service/work unit orientation resources are sourced and implemented to support new/transferring employees to achieve effective transition into a role in line with clinical, professional and organisational learning needs, work unit requirements and HHS/facility/directorate/service strategic/operational direction including values (MNHHS, 2015c; Queensland Health, 2011).
- HHS/facility/directorate/service policy/procedures that specify orientation/induction and ongoing legislative and mandatory training and assessment requirements for nursing/midwifery staff exist, are applied, and updated as requirements change (Queensland Health, 2018a).
- In accordance with policy all newly employed/transferred nurses/midwives attend orientation/induction that includes legislative, mandatory and requisite skill set requirements for classification and role (MNHHS, 2015c; Queensland Health, 2011 & 2018a).
- Nursing/midwifery applies a resource (e.g. tool/document) to risk rate HHS/facility/ directorate/service/work unit legislative, mandatory and requisite training and assessment requirements for each nursing/midwifery classification/role (Queensland Health, 2018a).

- Where applicable facility/directorate/service Clinical Service Capability Framework (CSCF) (Queensland Health, 2016d) should be consulted to determine the assessment of risks. Data pertaining to attendance, participant classification, designation, Full Time Equivalent (FTE) positions, and nursing/midwifery headcount is maintained and reported (MNHHS, 2015c; Queensland Health, 2011 and 2018a).
- Attendance data is available to line managers, Nurse/Midwifery Educators for review and reporting to determine successful completion of training and assessments, compliance in line with targets, and to initiate further transition support processes (MNHHS, 2015c; Queensland Health, 2011).
- Nursing/midwifery collaborates with other interprofessional colleagues in the development and review of HHS/facility/directorate/service/nursing/midwifery professional orientation/induction programs and resources to reduce duplication achieve efficiency, and meet expected outcomes.
- Orientation/induction programs, resources (e.g. Orientation Manuals) and legislative, mandatory and requisite assessment requirements are reviewed annually (MNHHS, 2015c; Queensland Health, 2011 and 2018a).

Newly employed/transferring nurses/midwives are supported to integrate lifelong learning into practice. As such these nurses/midwives are supported to effectively transition into a new classification and/or role by being provided opportunities to consider knowledge, skills and abilities required to fulfil role responsibilities within their defined scope of practice, and how these are applied to mitigate risk, and achieve safe patient outcomes. Furthermore, an essential component of successfully orientating/inducting, and transitioning a new/transferring employee is that they are well-versed about workplace values, responsibilities, and are acquainted with co-workers and specific work unit requirements. As such, all figures included in the Framework can be applied to facilitate orientation/induction and transition processes according to HHS/facility/directorate/service / work unit/professional, and individual learning needs, and stages of development.

10.2 Transition Process

Transition processes identified in the Framework refer to (but are not limited to) the programs, resources, support and time required to assist new or transferring staff successfully adjust to changes and prerequisites required when moving into a new classification and/or role. Therefore, transition is defined as:

> *...the period of learning and adjustment in which the new staff member acquires the skills, knowledge and values required to become an effective member of the health care team* (Fox, Henderson and Malko-Nyhan, 2005: p. 193).

When a newly employed nurse/midwife (irrespective of classification, role, and length of service or experience) commences in a new environment (facility/directorate/service/work unit), classification or role, there is a period before they feel confident and competent (Phillips, Kenny, Esterman and Smith, 2014). During this time nurses/midwives undergo change that requires them to socialise to role responsibilities, acquire knowledge, skills, values and attributes integral to their role, and consolidate critical thinking and reflection (Thorne, 2006). Moreover, HHSs/facilities/directorates/ services/work units are responsible for supporting nurses/midwives in the achievement/ maintenance of practice in line with relevant national standards. Hence, the provision of transition support for the new/transferring staff member during this period is perceived as crucial and an integral part of workforce planning (Haggerty, Holloway and Wilson, 2013). International and national literature has identified a direct correlation between the implementation of transition support processes and the long-term retention of nursing and midwifery staff (Booker, 2011; Earle, Myrick and Yonge, 2010; Haggerty, Hollaway and Wilson, 2013; Rush, Adamack, Janke, Gordon and Ghement,

2013a). Additionally, the "global nursing/midwifery shortage" and efficiency measures have accelerated the requirement to effectively transition nurses/midwives into new roles and the workplace (Aitken, Faulkner, Bucknall and Parker, 2002; Mehdaova, 2017; Rush et al., 2013a).

Transition support processes post initial Orientation/Induction programs are to be utilised for (but not limited to) any nurse/midwife who is:

- Moving to a new practice setting and/or classification or role (irrespective of classification and years of experience) (DHHS, 2014; MNHHS, 2015c; SA Health, 2014)
- Re-entering the workforce following successful completion of an endorsed program (for restoration of registration - after an absence of five (5) to ten (10) years) (ANMF, 2016)
- Seeking to return to practice after a period of absence greater than 12 months (MNHHS, 2015c; NMBA, 2013; Queensland Health, 2011)
- Entering the workforce for the first-time following completion of a pre-registration, pre-enrolment or pre-endorsement course (DHHS, 2014; MNHHS, 2015c; SA Health, 2014)
- Undertaking a Transition Support (TSP), Immersion (e.g. SWIM) or Accelerated Specialisation Program (DHHS, 2014; SA Health, 2014)
- Undertaking a postgraduate higher education program relevant to the specialty area of practice (DHHS, 2014; MNHHS, 2015c; SA Health, 2014)
- Undergoing any change or re-design to classification or role owing to transformations of HHS/facility/directorate/service/work unit.

Transition process components and resources as identified in the *Framework* do not represent a fixed period of time. The time to effectively complete transition processes is established by individual entry behaviours/knowledge/skills and achievement of standards of practice determined by the HHS/facility/service and/or work unit, nursing/midwifery and as relevant the HES (Queensland Health, 2011; Rush et al., 2013b). As such, timeframes will vary significantly dependent on the individual; nature and extent of transition processes required; and availability and effectiveness of infrastructure support.

To facilitate effective transition support to achieve expected standards contemporary literature espouses the value of integrating this support in some form throughout the entire first year of employment (Earle, Myrick and Yonge, 2010). Therefore, education programs specifically designed to support the development of nurses/midwives and aid progression through the transition phase of development encourage a:

> *...spirit of enquiry and learning that reaches far beyond the walls of academia where the foundations of professional practice have been established"* (Bridges et al., 2014: p.61).

Moreover, transition process support enables the nurse/midwife to effectively integrate into the health care team and work unit. The teaching and learning provision during transition should be through formal and informal support systems such as: Nurse/Midwifery Educators, Clinical Nurse/Midwife - Clinical Facilitators, preceptors, coaches, practice partners, and mentors. This support is primarily preceptorship based (or similar model) and should apply the tenets of preceptorship or similar program/s (e.g. coaching, supervision, mentoring), and implementation plan strategies related to changes in work or workplaces (Bridges et al., 2014).

Additional transition processes can be facilitated by (but not limited to the following):

- Self-directed CPD learning activities (Refer to ***Appendix 2: Examples of CPD Activities***)
- Reference to the relevant classification Generic Level Statements (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017])
- Career and Learning Pathways (Refer to ***Section 8.2.1: Career Pathways*** and ***Section 8.2.2: Learning Pathways***)
- Resources e.g. Orientation to a Classification or role; Clinical Learning Resources; Work Unit Development Maps (Refer to ***Section 10.3: Work Unit Development Maps***)

- Planned skill acquisition/assessment
- Seminar/clinical workshops/study days
- Transition Support (TSPs) or Immersion (e.g. SWIM)/Accelerated Specialisation Programs (MNHHS, 2015c; Queensland Health, 2011) (primarily relate to the nursing profession )

Standards for transition support process

Transition support is provided for all newly employed and transferring nurses/midwives to support a safe and effective transition into a new practice area, classification/role (MNHHS, 2015c; Queensland Health, 2011).

When a nurse/midwife enters the profession (e.g. New Graduate) or transitions from one area of specialisation to another (e.g. surgery to critical care; subacute medical to respiratory; clinical work unit to perioperative; clinical work unit to Clinical Nurse/Midwife - Clinical Facilitator/Clinical Coach) participation in more in-depth and longer transition support processes. These may include but are not limited to Transition Support and/or Immersion (e.g. SWIM) Programs  that may attract some form of recognition of prior learning status with the HES or a formal course of post graduate study leading to an award at a specified AQF level (AQF, 2013).

Standards for transition support process

- Transition support processes are included in all relevant HHS/facility/directorate/service /nursing and midwifery strategic and operational planning resources, and are aligned to service needs to promote workforce capacity and capability (MNHHS, 2015c; Queensland Health, 2011).
- Additional transition support processes including resources are in place and applied to facilitate accelerated learning opportunities for new graduates and other new/transferring staff.
- Adequate resources and infrastructure support are allocated to transition support processes and programs (MNHHS, 2015c; Queensland Health, 2011).
- Nurses/midwives undertaking a supporting role during transition should be adequately prepared via an endorsed training program (e.g. preceptors, coaches, Clinical Nurse/Midwife - Clinical Facilitators, Nurse/Midwifery Educators and mentors) (MTCETSC, 2007; Whitehead et al., 2013).
- The scope, and nature of support processes including formal programs offered (e.g. TSP, Immersion Programs [e.g. SWIM]; orientation to role) are recorded and reported (MNHHS, 2015c; Queensland Health, 2011).
- PDP provides a mechanism to negotiate and document individual transition support processes, engagement and outcomes. The scope, and nature of support processes including formal programs offered (e.g. TSP, Immersion Programs [e.g. SWIM]; orientation to role) are recorded and reported (MNHHS, 2015c; Queensland Health, 2011).
- PDP provides a mechanism to negotiate and document individual transition support processes, engagement and outcomes.

10.2.1 Transition Support (TSP), Immersion (e.g. SWIM) or Accelerated Specialisation Programs

TSPs, Immersion (e.g. SWIM) and/or Accelerated Specialisation Programs (primarily relate to the nursing profession) are contemporary, post registration, clinically focused, continuing professional development programs. These programs developed for specific cohorts assist the newly graduated or transferred nurse/midwife to acquire further general and speciality knowledge and skills in a logical, sequenced supported approach to effectively transition to work expectations (Queensland Health, 2012). As such, the HHS/facility/directorate/service provides appropriate support processes and resources to assist participants achieve the tenets and learning outcomes of the relevant TSP, Immersion (e.g. SWIM) or Accelerated Specialisation Program. Nurse/Midwifery Educators in consultation with line managers assume a lead role in coordinating and supporting nurses/midwives undertaking these independent learning programs within curricula or outcome criteria (Queensland Health, 2012).

Moreover, these programs are recognised as an effective approach to accelerate learning, enhance communication and leadership skills, and support the new nurse/midwife with diverse individual learning needs (Queensland Health, 2012). Likewise, they have been identified as an effective mechanism to expedite an individual's transition to become confident and competent for practice within a new setting.

TSPs, Immersion (e.g. SWIM) and/or Accelerated Specialisation Programs (e.g. Perioperative; Mental Health, Paediatric) are delivered via various methods including (but not limited to): flexible self-directed learning modules, face to face workshops/sessions; video/streaming, simulation and clinical observation. Programs aim to accelerate the participant's engagement in learning within an area of speciality practice whereby the crucial elements are provided to assist safe transition into the workplace. They also enable the inexperienced colleague to function more effectively within a short period of time in the new area of practice to a basic safety standard with supervision. The programs which comprise theoretical and clinically focussed activities encourage participants to reflect on their knowledge skills and abilities and provide a pathway for advancing scope of practice. Learning throughout each program also occurs by completion of assessment items. Self-reflection activities are likewise encouraged to promote learning from experience and to assist the nurse/midwife to synthesise, analyse and transfer knowledge and skills from one context to another by stimulating critical thinking (Queensland Health, 2012).

Workplace support for participants of these programs should include (but is not limited to): preceptor support and/or coaching from experienced clinicians working in the specialty area with gradual withdrawal of support as the nurse/midwife's knowledge and skills develop. Additionally, further assistance can be attained through formal and informal mentoring. In consultation with other key stakeholders, Nurse/Midwifery Educators co-ordinate, maintain data and report on participant engagement and achievements in these programs. The progress of the nurse/midwife through the transition process is monitored by using the principles of PDP. Therefore, to achieve optimal outcomes during the transition process, learning and development milestones are utilised as markers to monitor the progress of the nurse/midwife against predetermined criteria (e.g. activities/assessments).

Furthermore, development, implementation and sustainability of these programs should not occur in isolation, but include engagement with key nursing/midwifery stakeholders and others (but not limited to), e.g. HHS nursing/midwifery governance, professional organisations, colleges, special interest groups and networks, and HES partners. Additionally, to encourage continuing engagement in a pathway of lifelong learning the nurse/midwife is encouraged to apply for advanced standing towards a relevant postgraduate program following the successful completion of all components of a program within the specified time frame.

Standards for Transition Support, Immersion (e.g. SWIM), Accelerated Specialisation Programs

Transition Support, Immersion (e.g. SWIM) and Accelerated Specialisation Programs are provided for newly employed and transferring nurses/midwives to assist in accelerating and consolidating learning to support a safe and effective transition into a new clinical practice environment.

Please note that the following standards are to be used in addition to application of those in ***Section 10.2: Transition Processes***.

Standards for Transition Support, Immersion (e.g. SWIM), Accelerated Specialisation Programs

- The HHS/facility/directorate/service is responsible for providing Preceptor (or other similar model, e.g. coaching) train the trainer and training programs to build experienced staff capacity and capability in supporting new/transferred colleagues.
- The HHS/facility/directorate/service is responsible for providing preceptor (or other similar model) support for all newly employed/transferred nursing/midwifery staff by an experienced clinician who has undertaken formal preparation for this role (MTCETSC, 2007; Whitehead et al., 2013).
- The HHS/facility/directorate/service/work unit is responsible for providing adequate resources and infrastructure support to enable effective participant engagement in transition support processes and similar relevant context specific programs (MNHHS, 2015c; Queensland Health, 2011; Rush et al, 2013b).
- Preceptor (or other similar model) support occurs initially via direct supervision that is gradually withdrawn over a negotiated period of time in accordance with individual learning needs and demonstrated consolidation of learning resulting in safe practice (Refer to ***Section 12.1: Preceptorship***).
- The lived experiences, scope and context of practice of the newly employed/transferring nurse/midwife must be considered prior to determining the nature and scope of transition support processes and program of learning.
- Transition support resources are provided as soon as practicable following employment/transfer to facilitate achievement of program requirements as per milestones and PDP initiation. A *Work Unit Development Map* can be used as a pathway that indicates learning expectations during the transition phase.
- The scope and nature of support processes including formal programs (e.g. TSP, Immersion [e.g. SWIM], Accelerated Specialisation, Orientation to Role) are recorded and reported (MNHHS, 2015c; Queensland Health, 2011).
- PDP provides a mechanism to negotiate and document individual transition support processes, engagement and outcomes.

The transition support processes including the standards identified above are applicable for both experienced and inexperienced colleagues transitioning to roles requiring specialist knowledge and skills in speciality practice work units (e.g. Critical Care, Perioperative, Neonatal, Mental Health, Neurosurgical, Respiratory, Renal Dialysis, and Cancer Care). While transition support processes apply to every new/transferring or developing nurse/midwife, additional considerations are required in supporting a new graduate's transition into the profession and workplace.

10.2.2 Early Career (New Graduate) Transition Support Considerations

The importance of the application of structured transition support processes during the first year of practice for newly qualified nurse/midwives is reinforced by key objectives in the Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB9) (2016). Accordingly, to achieve effective workforce capacity building and best practice standards outcomes it is essential that newly graduated nurses/midwives have access of opportunity to the following transition support processes as they embark on their work life and professional journey:

- Orientation/Induction (Refer to ***Section 10.1: Orientation and Induction***)
- Preceptor support (Refer to ***Section 12.1: Preceptorship***) in line with individual clinical, professional and organisation learning needs, and context of practice
- Supervised and guided clinical learning
- Work-based programs designed to consolidate knowledge skills and values (e.g. CPD, TSP, Immersion (e.g. SWIM), Accelerated Specialisation Programs)
- Career/succession planning (Refer to ***Section 12.5: Mentoring*** and Section ***12.6: Succession Management***)

In addition, counselling support (where relevant), dialogue regarding professional and organisational values, socialisation, cultural awareness and the generic level statement domains (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) are integral to achievement of effective new graduate transition. Support processes such as those above, facilitate attainment of a workforce able to demonstrate relevant skills, 'best fit' and right qualifications for a role. Additional early career support combined with effective supervision and learning these should achieve safe, high quality patient care (Australian Council on Healthcare Standards [ACHS], 2017).

New Graduate Additional Standards for Transition Support

Please note that the following standards are to be used for new graduate nurses/midwives in addition to application of those in ***Section 10.2: Transition Process*** and ***Section 10.2.1 Transition Support (TSP), Immersion (e.g. SWIM) or Accelerated Specialisation Programs***.

Additional transition support is provided for all newly graduated nurses/midwives to accelerate their ability to consolidate learning and effectively transition into a new practice area to meet work unit context specific needs and specialisation requirements to a safe competent standard (El Haddad, 2016; MNHHS, 2015c; Queensland Health, 2011).

New Graduates Additional Standards for Transition Support

- All new graduates are offered more focussed transition support than other new/transferred employees, e.g. (but is not limited to) Transition Support, Immersion (e.g. SWIM), Accelerated Specialisation Programs, face to face workshops, clinical supervision and reflection in action activities.
- Transition support resources are provided as soon as practicable following employment/ transfer to facilitate achievement of program requirements as per milestones and PDP initiation. A *Work Unit Development Map* provides learning pathway expectations during the transition phase (Refer to ***Section 10.3: Work Unit Development Maps***).
- The tenets of cultural awareness, values clarification, socialisation and change management should be embedded across the components of any transition support process (e.g. programs, dialogue and feedback).
- The HHS/facility/directorate/service is responsible for providing additional new graduate infrastructure support including strategies to facilitate preceptor/preceptee relationships and achievement of outcomes e.g. Clinical Nurse/Midwife - Clinical Facilitator role/workshops/ resources.
- The HHS/facility/directorate/service is responsible for allocating a minimum of 2 weeks rostered supernumerary time per the BPF (OCNMO, 2016) (or as per HHS/facility/ directorate/ service processes) to facilitate effective and timely new graduate transition to the workplace/ unit.
- Preceptor support for the new graduate is provided by an experienced clinician who has undertaken formal preparation for this role. This support occurs initially via direct supervision and is gradually withdrawn over a negotiated period in accordance with new graduate learning needs and demonstrated consolidated of learning resulting in safe practice (Refer to ***Section 12.1: Preceptorship***).
- Physical and psychosocial safety incorporating respect for individual experience and scope of practice are core considerations in supporting successful transition of the new graduate to the workplace.
- The new graduate is provided feedback (written and verbal) which is documented within their PDP regarding their value, and contribution to the role and work unit.
- Staff within the work unit encourage the new graduate to reflect on practice, their communication, and collaboration with the interprofessional team to enhance transition to work unit, and professional expectations.
- It is the responsibility of each nurse/midwife to: effectively support the socialisation and workplace collaboration; and to role model and teach according to the new graduate's learning needs (e.g. time management, prioritisation, clinical and technical skills, interprofessional relationships, and workplace values).

A *Work Unit Development Map* (e.g. a form of learning pathway) has been found to be a useful tool for assisting new and transferring colleague's transition to a HHS/facility/directorate/service/work unit and role. The following section provides insight into how a tailored *Work Unit Development Map* can be successfully applied as a support process.

10.3 Work Unit Development Maps

The *Work Unit Development Map* (e.g. of a learning pathway) depicted as ***Figure 6*** is a nonspecific representation of noteworthy progressive learning stages, aligning mechanisms, structures, supports and influences that provide context for CPD and lifelong learning (MNHHS, 2015c; Queensland Health, 2011). The *Work Unit Development Map* summarises key elements of development required by a nurse/midwife throughout the continuum of learning of their work life.

The expectation is that as a learning pathway a Work Unit Development Map (***Figure 6***) can be contextualised to any work unit and be applied at every stage of a nurse/midwife's career in relation to where they fit from a developmental perspective (e.g. new graduate, experienced RN/midwife, or RN specialisation) to meet individual learning needs. For example, a new graduate nurse/midwife would commence Orientation and progressively move along the continuum with support according to needs. Similarly, a newly transferred or newly employed experienced nurse/midwife would also complete these requirements; however, they would be expected to transition more promptly to career development and lifelong learning activities through transfer of existing knowledge, skills and life experiences. As such, individual, clinical, professional and organisational learning needs must be considered throughout each phase of the pathway in accordance with the specific service, work unit and role expectations.

The three (3) *Spheres of Learning (Clinical, Professional* and *Organisational)* (Refer to ***Section 9: Clinical Professional and Organisational Learning***) at the extreme left of the diagram identify that each nurse/midwife must consider each sphere of learning to capture the nature of integration and diversity of learning that occurs across each phase of the pathway in order to achieve safe, competent practice and quality consumer outcomes across the continuum of learning during one's work life (MNHHS, 2015c; Queensland Health, 2011).

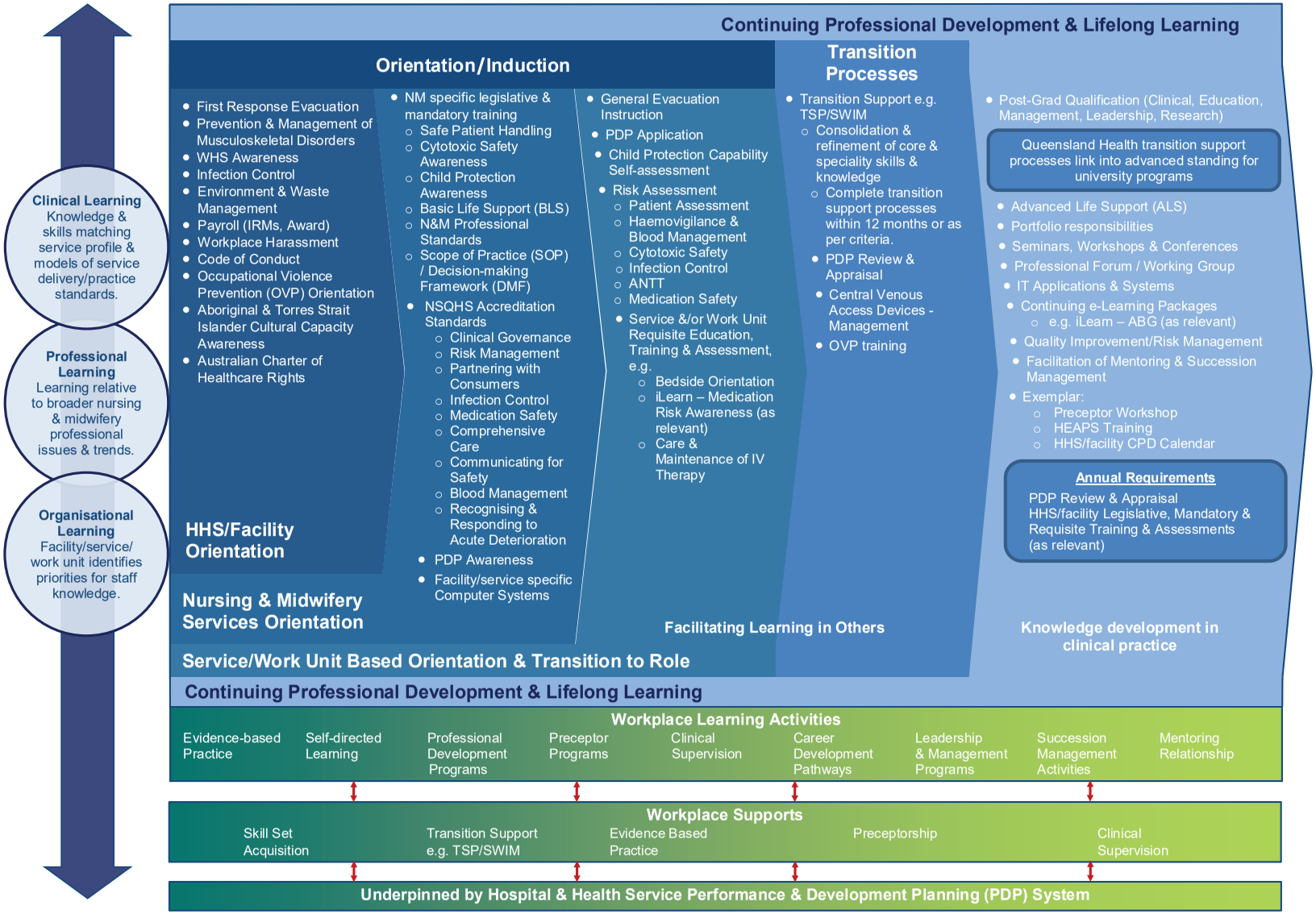
The upper components of the diagrammatic representation (Orientation/Induction, Transition Process, Continuing Professional Development, and Lifelong Learning) depict the progressive learning phases of a *Learning Pathway*. Broad examples of expected knowledge and skills for a classification/role have been identified for each phase.

> ***N.B.*** *These are broad examples only (**Figure 6**) and must be modified to the context of practice for any nursing/midwifery role or specialisation. As such, the training and skill sets identified within each learning phase are samples of legislative, mandatory and requisite training requirements.*
>
> *Please access existing HHS/facility/directorate/service procedures/policies or a nursing/midwifery Legislative, Mandatory and Requisite Skills Register (Refer to **Appendix 5: Broad snapshot of a sample Legislative, Mandatory and Requisite Skills Register**) or similar resources when populating this section of a Work Unit Development Map from a work unit context perspective*

In addition, the two lower components of ***Figure 6*** are foundational processes *(Workplace Learning Activities and Workplace Supports)*, applied to encourage effective active learning across the pathway to achieve milestones, assessment criteria and expected outcomes.

Collectively, each component of the *Work Unit Development Map* (spheres of learning, phases of transition, workplace activities, and supports) are underpinned by the HHS PDP System identified in the lowermost section of the representation. PDP supports formalisation, monitoring and feedback in respect to expected progress and outcomes (Refer to ***Section 13.1: Performance and Development Planning [PDP]***)

Figure 6: Broad Sample of a Work Unit Development Map (example of a Learning Pathway)



Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)

***N.B.** Work units are encouraged to contextualise the provided Work Unit Development Maps to the practice context (by adding work unit name). Specific work unit requirements in respect to legislative, mandatory, requisite training, upskilling and CPD should be considered in respect to professional requirements. All new/transferred employees should be provided with a Work Unit Development Map aligned with PDP.*

Moreover, there is an expectation that a Nurse/Midwifery Educator will collaborate with key stakeholders to apply a *Work Unit Development Map* or similar learning pathway for each area of clinical practice. This will assist with: contextualisation of training; determination of skill sets and timelines through assessment; alignment with role description and work unit service delivery requirements (MNHHS, 2015c; Queensland Health, 2011; Rafferty, Xyrichis and Caldwell, 2015). *Work Unit Development Maps* should be: published within the work unit; made available to all nursing/midwifery staff; be negotiated; and included in the individual's PDP. Each *Work Unit Development Map* (***Figure 6***) is updated annually or as required.

Further, Nurse/Midwifery Educators and experienced staff within the work unit (e.g. preceptor/coach) provide ongoing support and guidance to facilitate effective participant engagement and achievement of the milestones and assessment criteria of the relevant Work Unit Development Map. The line manager provides feedback and documents progress through the *Work Unit Development Map* milestones in the individual's PDP.

Refer to ***Appendix 4: Examples of Work Unit Development Maps*** pertaining to:

- New Graduate
- Paediatric Nurse
- Perioperative Midwife
- Midwife
- Critical Care (ICU) RN without post graduate critical care qualifications
- Critical Care (ICU) RN with post graduate critical care qualifications
- Critical Care Grade 6 Clinical Nurse Band 1

11. Clinical Placement and Student Support Processes

The importance of providing effective clinical placement experiences for student nurses/midwives cannot be underestimated by the profession. While current demand for clinical placements appears to outstrip supply, without meaningful industry and HES partnerships offers and the nature of clinical placements will be impacted, and students will not gain appropriate clinical exposure required to prepare them to be safe competent clinicians (Courtney-Pratt, FitzGerald, Ford, Marsden and Marlow, 2012; National Health Workforce Taskforce (NHWT), 2009).

James and Chapman (2010) conclude that the clinical experience, together with student expectations and a respectable understanding of the professions of nursing/midwifery, become pivotal in the journey of the preregistration nursing/midwifery student.

With changing nursing/midwifery age demographics the main source of the future workforce will be through preparation of students with ability to effectively transition into a new graduate position. Accordingly, to achieve successful workforce capacity, capability and best practice standards for this cohort, it is essential that student nurse/midwives are nurtured and supported by the profession especially when undertaking clinical placement.
Consequently, student nurse/midwives should be provided:

- Clinical Placements in a workplace unit that facilitates a positive culture of learning, and supports realistic, and meaningful engagement, achievement of clinical skills, knowledge, and professional socialisation that cultivates productive and competent contribution to consumer outcomes and the health care system.
- Clinical placement opportunities that are meaningful and consolidate theory, and practice in line with the relevant HES expectations and student scope of practice to assist in achieving registration at the completion of the course of study.
- Access of opportunity to quality, and varied clinical placement allocations to support sequential integration into the workplace, and consolidation of learnings to enable achievement of expected standards and the provision of self-sufficient, safe, competent person-centred care during transition from student to new graduate.
- Effective learning support by each nurse/midwife (including buddies, preceptors and student facilitators and others) who readily share their knowledge and practice in a professional meaningful manner when guiding, directing and supervising nursing/midwifery students to achieve best practice care.
- Objective supervision, and consistent feedback by facility/directorate/service nursing/midwifery staff regarding performance, to facilitate confidence and competence with the relevant standards of practice and assessment criteria.
- Effectual assessment (in line with the HES criteria) that is timely and meets principles of equity and natural justice.
- Opportunities to engage with HHS, facility/directorate/service nursing/midwifery staff in relation to addressing placement matters, incident management, complaints/compliments and professional support.
- A point of contact who co-ordinates clinical placements, supports and guides both student facilitators and students – as per HHS, facility/directorate/ service processes.
- Positive perceptions, and role modelling regarding the nursing/midwifery profession.

To support achievement of the above, annual review and negotiation of clinical placement capacity, clinical work unit allocation, and placement model/s should be undertaken. This approach assists in confirming each facility/directorate/service/work unit within a HHS is providing the most effective and appropriate clinical placement offers to HES partners, and are championing the development of the future professional nursing/midwifery workforce.

12. Supporting Relationships to Build Capacity

Relationships between co-workers are extremely important as the means of achieving goals, given people do not work in isolation, and every relationship is different due to what they can offer or share to achieve a common goal. However, once formed, attention, effective communication, loyalty, appreciation of needs and nurturing are ongoing requirements to maintain the relationship.

Further, effectively developing and maintaining work-based relationships can be individually and professionally rewarding as well as provide an opportunity to support capacity building for other nursing/midwifery colleagues. The focus on building capacity in workplace relationships is on interacting collaboratively with others to strengthen performance and engagement, identifying opportunities for improvement, and increasing the impact of return on expectations (National Scientific Council on the Developing Child, 2015).

An individual taking the lead in a supportive relationship should facilitate the other person to target development of specific skills needed for adaptive coping, sound decision making, effective self-regulation and the learned ability to adjust to change and new challenges (National Scientific Council on the Developing Child, 2015).

The nature of supportive relationships in the workplace can take multiple forms dependent on the context of practice, development needs of the individual and role. Formal and informal supportive processes may include (but are not limited to) preceptorship, coaching, clinical supervision, succession management and mentoring. A commonality between preceptors, mentors, and coaches is an interest in the development of others.

12.1 Preceptorship

Preceptorship is a formal planned short-term relationship between an experienced nurse/midwife (preceptor) and new/transferred nurse/midwife (preceptee), which is designed to assist successful transition, adaption to role responsibilities, and achievement of performance expectations (Kalischuk, Vandenberg and Awosoga, 2013; Nielsen et al., 2017; Queensland Health, 2010; Valizadeh, Borimnejad, Tahmanim Gholizadeh and Shabazi, 2016). The nature and length of this formal relationship is dependent on the new/transferred nurse/midwife's lived and professional experiences, scope of practice, work unit context, individual and organisational performance goals (Muir, Ooms, Tapping, Marks-Maran, Phillips and Burke, 2013; Henderson, Fox and Armit, 2008)

Internationally preceptorship is well considered as an effective mechanism to build a supportive teaching and learning relationship, to expedite a smooth transition from learner to an independent member of the health care team (Henderson, Fox Armit, Fox, 2008; Ke, Kuo and Hung, 2017; Myrick and Yonge, 2005; Nielsen et al., 2017; Shinners and Franqueiro, 2015; Weselby, 2014; Whitehead, Owen, Henshaw, Beddingham and Simmons, 2015; Valizadeh et al., 2016). To facilitate optimum transition, preceptorship should occur in a nurturing and well-structured environment where there is a fundamental responsibility to provide support, manage change, and facilitate open communication (Bengtsson and Carlson, 2015; Hughes and Fraser, 2011; Kelly and McAllister, 2013). Furthermore, commitment by managers and other key stakeholders is integral to the success of the preceptorship experience (Bowen, Fox and Burridge, 2012; Whitehead et al., 2015; Valizadeh et al., 2016).

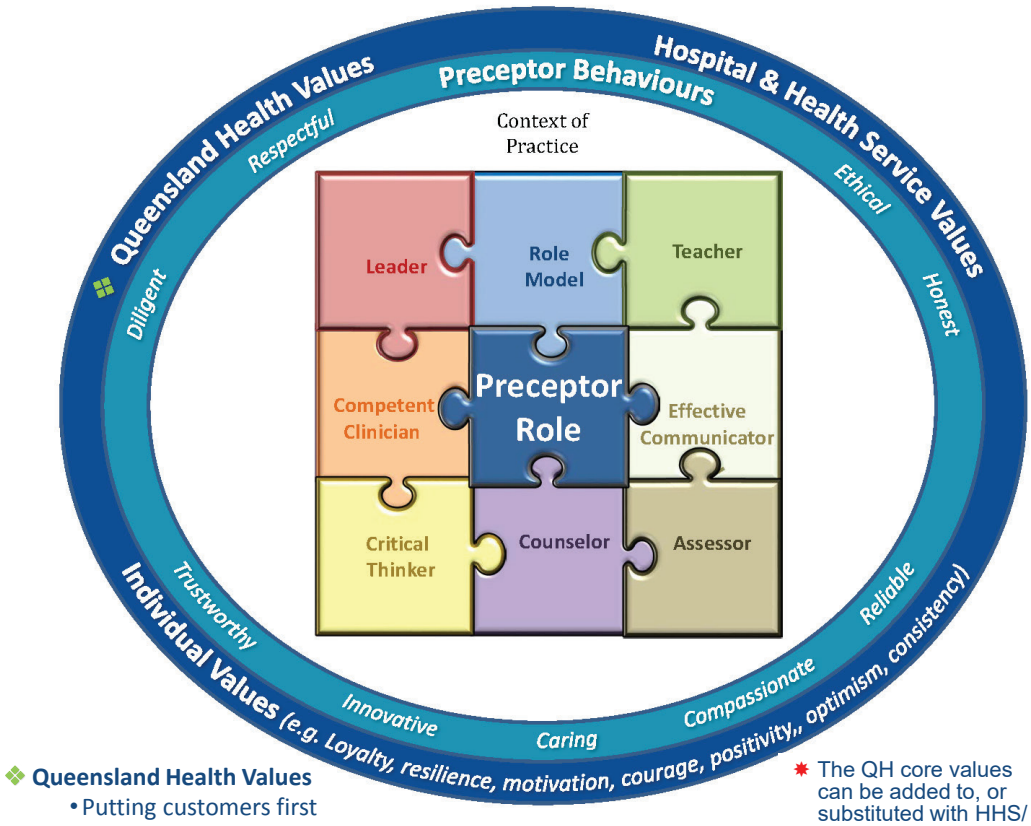
Additionally, preceptorship is a complex dynamic education process comprising design and implementation of various teaching and learning strategies that incorporate ethical principles and unite theory and practical requirements to reduce gaps (Bengtsson and Carlson, 2015; Carlson, Pilhammar and Wann-Hansson, 2010; Henderson, Fox and Armit, 2008; Hilli, Melender, Salmu and Jonsén, 2014; Kalischuk et al., 2013; Valizadeh 2016). The preceptorship relationship is viewed as fundamental in clinical practice and should be

grounded in mutual openness via supportive processes in a nurturing environment as it provides feedback regarding performance and assists transition towards independent decision making, critical thinking, setting priorities, managing time, and providing skilled patient care (Kelly and McAllister, 2013; Matua, Seshan, Savithri and Fronda, 2014; Valizadeh et al., 2016).

The literature identifies a preceptor as an experienced nurse/midwife/resource person who plays a pivotal role in the transition of staff from novice to required performance expectations by guiding and role modelling their knowledge, skills and practice to increase confidence and enhance practice (Bengtsson and Carlson, 2015; Muir et al., 2013; Panzavecchia and Pearce, 2014; Valizadeh et al., 2016). As such, the scope of the preceptor role is diverse and comprises many concurrent responsibilities including (but not limited to): leading, role modelling, counselling, supporting socialisation, effective communication, teaching and coaching, skill and learning opportunity facilitation, critical thinking, guiding monitoring and assessing performance (Bowen, Fox and Burridge, 2012; Henderson, Fox, and Malko-Nyhan, 2006; Kallenbach, 2016; Trede, Sutton and Bernoth, 2015; Shinners and Franqueiro, 2015).

Figure 7 illustrates the relationship between fundamental inter-woven responsibilities of the preceptor role (inner multi coloured section); individual behaviours (first outer section) and organisational and individual values (outermost section) that can influence how effective the preceptor is in establishing and maintaining their relationship with a preceptee. All interwoven responsibilities as depicted are of equal value in demonstrating effective application of the preceptor role. However, given situational context a preceptor may focus one or a combination concurrently in their efforts to support the preceptee to build capacity.

Figure 7: Diagrammatic Representation of Preceptor Role



As identified in ***Figure 7*** values, behaviours, and application of ideal interwoven preceptor role expectations can have a long-term influence on a preceptee in enhancing socialisation; creating a conducive teaching and learning environment; shaping clinical experiences, their career, and quality of patient care (Bowen, Fox and Burridge, 2012; Gopee, 2008; McCusker, 2013; Ward and McComb, 2017). Hence, consideration of the preceptor's personal values and attributes, and their ability to effectively fulfil role responsibilities is important in achieving required outcomes (Bengtsson and Carlson, 2015; Henderson, Fox and Malko-Nyhan, 2006; Shinners and Franqueiro, 2015). Simply assigning a new starter to another colleague named as a 'preceptor' or 'buddy' will not guarantee quality workplace training and clinical competence (Bengtsson and Carlson, 2015). To achieve the best preceptorship outcomes preceptors, need effective training and where possible post graduate awards. Similarly, organisations have an obligation to provide them with requisite knowledge and skills required to achieve expected preceptorship outcomes (Bengtsson and Carlson, 2015). Hence, the availability of suitably trained preceptors is important in maximising opportunities to guide and support new staff, and for fostering an environment for learning where practice is valued and developed (Bengtsson and Carlson, 2015; Bowen, Fox and Burridge, 2012; Gopee, 2008). Therefore, preceptorship should be planned in the context of the individual's facility/ directorate/ service/work unit and professional responsibilities. Learning undertaken and the documentation of such learning in PDPs should relate to role expectations thereby reducing duplication of effort by both the preceptor and preceptee (Morley, (2013; Nielsen et al., 2017; Queensland Health, 2011).

Applied successfully the application of an effective preceptorship model achieves the following benefits:

- Clarification of employment expectations
- Promotion and encouragement of an open honest and transparent culture among staff
- Supports the delivery of quality efficient health care
- Signifies organisational commitment to learning
- Provides access support in embedding values and expectations of the HHS and profession
- Attracts and retains staff
- Fosters career progression and satisfaction
- Mitigates risk by providing access to trained experienced staff willing to guide and support others in the development of their practice (Ke, Kuo and Hung, 2017; Myrick and Yonge, 2005; Muir et al., 2013; Nielsen et al., 2017; Queensland Health, 2010; Weselby, 2014; Valizadeh et al., 2016).

Standards for Preceptorship

Preceptor support is provided to new and transferring nurses/midwives in line with the endorsed HHS/facility/directorate/service preceptorship processes and resources that facilitate effective transition to the role and workplace (Muir et al., 2013; Ke, Kuo and Hung, 2017; Valizadeh et al., 2016).

Standards for Preceptorship

- Preceptorship operates within a nursing/midwifery governance framework (Queensland Health, 2010; Whitehead et al., 2015).
- Preceptorship key stakeholders support the application and maintenance of the endorsed HHS, facility/directorate/service preceptorship model and resources, and work collaboratively to enhance the preceptor/preceptee relationship and return on expectations (Bowen, Fox and Burridge, 2012; Ke, Kuo and Hung, 2017; Matua et al., 2014; Queensland Health, 2010; Whitehead et al., 2015).
- Contemporary evidence-based educational resources for the preparation of preceptors are maintained by nursing/midwifery across a HHS to reduce duplication of effort and uphold collective standards (Bengtsson and Carlson, 2015; MNHHS, 2015c; Muir et al, 2013; Queensland Health, 2010 and 2011).
- A pool of appropriately prepared/trained preceptors is sustained within each HHS facility/directorate service to pre-determined minimum standards and targets (e.g. 30%) to facilitate effective role functioning, and accommodate needs associated with new starter and preceptor recruitment and attrition rates (Ke, Kuo and Hung, 2017; MNHHS, 2015c; Queensland Health, 2011; Weselby, 2014).
- HHSs/facilities/directorate/services provide training, regular updates (e.g. every 18 months) and support the preceptor to undertake the role, and monitor effectiveness through training registers, program evaluation, and reflection in action feedback (Bengtsson and Carlson, 2015; MNHHS, 2015c; Muir et al, 2013; Queensland Health, 2010 and 2011).
- Preceptor roles, responsibilities and development requirements are included within the PDP of the preceptor as a determinant of effective functioning within the role (MNHHS, 2015c; Queensland Health, 2011; Whitehead et al., 2015).
- Every newly graduated/transferred nurse/midwife is allocated Preceptor/s (team approach if relevant) on commencement of employment (MNHHS, 2015c; Queensland Health, 2011; Whitehead et al., 2015).
- Where possible there should be consistency in allocation of preceptor support to the new new/transferred employee, and includes rostering the same preceptor/ preceptee shifts.
- The principles of Recognition of Prior Learning (Refer to ***Section 13.2 Advanced Standing/ Recognition of Prior Learning***) for Preceptor Training/Program attendance are applied to reduce duplication and maintain minimum standards (Bengtsson and Carlson, 2015; MNHHS, 2016; QUT, 2015a and 2015b).
- The number of active preceptors, training workshops and updates and are recorded and reported at least annually (against predetermined targets).
- Each nurse/midwife who undertakes a supporting relationship role (such as, those outlined in this Section), is adequately prepared and supported to fulfil the role (Bengtsson and Carlson, 2015; MTCETSC, 2007; Whitehead et al., 2013).
- Newly employed and transferring nurses/midwives are to be provided with learning and development opportunities to build clinical workforce capacity and capability (Ke, Kuo and Hung, 2017; OCNMO, 2013a; Whitehead et al., 2015).

The tenets and standards provided within this section have been expanded from original work undertaken to develop a statewide Preceptor Model and Program (Queensland Health 2001, 2006, 2010) whereby relevance to the Queensland context informed development and application. Therefore, it is recommended that each HHS, facility/directorate/service not only applies the above tenets and standards of preceptorship, but also embeds this important nursing/midwifery supportive process within strategic and education plans to achieve best practice and capability against pre-determined KPIs.

Preceptorship, coaching and mentoring have widely been recognised as effective workforce planning, development and capacity building strategies (Whitehead, Dittman and McNulty, 2017). More than ever individuals and organisations are recognising the benefits of implementing and integrating these and other supportive relationship strategies to facilitate a culture of development, and career advancement as well as the effective management of knowledge capital (Whitehead, Dittman and McNulty, 2017).

12.2 Coaching

Coaching is a collaborative relationship between a coach and a staff member with the aim of uncovering potential to maximise performance, learning and development. This approach is viewed as a mechanism to increase motivation and productivity, improve communication, networks, greater self-awareness, and an enhanced appreciation of one's career path (Arnold, 2016; Medd, 2011; Jones, 2015).

However, coaches work with individuals and teams in a different manner to that of preceptors or mentors and are not necessarily content experts with a specific knowledge base or provide guidance, instruction, advice or solutions (Bond University, 2018; Jones, 2015). Rather they focus on supporting the individual to expand learning about themselves; identify areas for development and encourage them to develop their own capabilities through structured consideration of different options, to become self-aware of choices and plan actions (Arnold, 2016; Jones, 2015).

Coaching may assist the individual to:

- Develop skills (time management, budgeting, presentation skills)
- Improve performance dependent on identified gaps
- Focus on solutions (identify and address issues, problem solving)
- Be results oriented (goal setting and action planning)
- Focus on personal and professional development (career or leadership) (Arnold, 2016; Bond University, 2018).

While coaching, preceptoring and mentoring use similar approaches coaching generally focuses on immediate goals and developmental issues individually or within small groups. Additionally, this approach with a focus on one's goals and vision can be used for a variety of intents such as: performance, skills, work shadowing, team facilitation, career, personal and executive coaching (Bandura and Lyons, 2017; Jones, 2015).

Coaching is viewed as an effective mechanism for enabling an organisation to meet competitive pressures, plan for succession and bring about change (Riddle, Hoole and Gullette, 2015). Particular organisational situations where coaching may be appropriate as a development intervention include: talent shortages; long term performance improvement; behaviour change achievable in short time frame; organisational change; future leaders or senior executives. However, while coaching is considered an effective development tool, its success rests with application to specific need and intention (Jones, 2015; Riddle, Hoole and Gullette, 2015).

Although coaching is a method of improving individual or team performance through direction and instruction its application will vary across and between HHSs/facilities/directorates/services. Therefore, reference to specific processes, resources and contexts is recommended. Furthermore, in some HHSs/facilities/directorates/services coaching is used with success to support supervised practice and clinical supervision approaches (Arnold, 2016; Bandura and Lyons, 2017; Jones, 2015).

12.3 Clinical Supervision

Supervision and support practices, as part of workforce development can be useful to assist with recruiting staff, retaining valuable staff, supporting and encouraging good practice, worker well-being, and engaging in reflective practice (Mental Health Coordinating Council [MHCC], 2008; Scottish Social Services Council [SSSC], 2016). Therefore, supervision performs an educative and supportive function by presenting opportunity to raise professional issues and gain further expertise by encouraging individuals to learn from their own experiences in working with consumers, review and debrief approaches to performance (recovery-oriented support practices as applied to mental health), and confirm service delivery is following best practice standards. (Australian Government, 2010; Slade et al., 2014; SSSC, 2016).

> *Clinical supervision is a support mechanism for practicing professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills. This process will lead to an increased awareness of other concepts including accountability and reflective practice. (Lyth, 2000: p.728).*

It is a formal process of support and reflection which may occur in a dyad or within a small group. Nursing/midwifery clinical supervision is situated within a wider framework of governance activities designed to support staff and promote quality patient care (Bifarin and Stonehouse, 2017). However, it is separate to activities such as preceptorship, line management support, performance development planning and mentoring (Bifarin and Stonehouse, 2017; Queensland Health (2009).

Clinical supervision acknowledges an exchange between practicing professionals which may promote debate, challenge existing thinking and generate solutions to problems in practice while fostering personal awareness and addressing areas of practice that may be of concern to the clinician. It also promotes reflective practice informs professional development and engagement in lifelong learning and encourages professional exchange, improved services, recruitment, retention and efficiency. Moreover, clinical supervision can function as a tool to support components of clinical governance such as, quality improvement, risk and performance management and systems accountability (ACSA, 2015; Bifarin and Stonehouse, 2017; Jones, 2006; Lyth, 2000).

The effective relationship between the clinical supervisor and the individual is nurtured within a safe environment where dialogue and reflection can occur freely as is relevant to any other supportive relationship. While clinical supervision has previously been adopted primarily within the mental health, application of this supportive capacity building process is gaining momentum across nursing/midwifery (ACSA, 2015; Bifarin and Stonehouse, 2017; Jones, 2006).

Please note that in applying the principles of clinical supervision the focus is on the supportive relationship, awareness raising, sharing, and enhancing development, accountability and reflective practice. This approach varies from the short-term, specific intent supervision of nursing/midwifery students and staff where capacity is built but the timeframe precludes the opportunity for ongoing relationship building. However, in any form of supervision refection which is a characteristic of professional practice should be undertaken by all nursing/midwifery colleagues as it promotes the development of personal and professional growth, and is associated with improvement of quality of care (Morgan, 2009).

Reflective practice in supervision provides a unique opportunity for staff to be encouraged and supported to understand and incorporate the values and philosophies of the organisation, e.g. genuine consumer and carer participation, cultural sensitivity, recovery-oriented services and evidence-based practice (IpAC Unit, n.d.)

12.4 Reflective Practice

Reflective practice is a professional development technique that involves thoughtfully considering one's own experiences in applying knowledge to practice while being coached by professionals in the discipline (Ferraro, 2000; Schön, 1987). Reflective practice involves becoming intellectually engaged in activities tailored to amend practices by transforming knowledge (MacNaughton, 2003). Intrinsically it is a unique part of staff development and service delivery that should be embedded in all organisational practices, e.g. supervision, evaluation, performance management, cultural competence, and forming partnerships. As such, reflective practice is a self-regulated and continuous process that requires the individual to either:

- 'Reflect-in-action' – i.e. look to experiences; connect with feelings and individual frames of reference (i.e. understanding, or think and react quickly).
- 'Reflect-on-action' – i.e. thinking back to something and exploring why one acted in a specific manner and then writing or talking about it with a supervisor (Edwards, 2017; Mann, Gordon and MacLeod, 2009).

Therefore, reflection is a highly personal continuous process that requires a professional to consider daily experiences, internalise them, deliberate and filter these new thoughts through previous lived experiences and personal values and biases, before deciding how best to proceed to adjust practice, views and behaviour (Edwards, 2017; Mann, Gordon and MacLeod, 2009). Reflective practice is a feature of high quality learning environments and can be spontaneous, deliberately planned, and individual or involve others.

Considering the nature of nursing/midwifery, reflection on past experiences and practices provides a critique that assists with review of assumptions about learning and development, and questions beliefs and values an individual brings to their practice (Alden and Durham, 2012). In nursing/midwifery reflection can expand to incorporate self-exploration, practice development, and transformative lifelong learning (Edwards, 2017). It also promotes development of critical understanding of individual practice and continual development of skills, knowledge and approaches to achieve best outcomes and foster career development (Alden and Durham, 2012; Edwards, 2017).

Nurturing staff is an important factor in effective practice and building capacity for teams and individuals. Therefore, ongoing reflection by Nurse/Midwifery Educators is crucial in respect to what, how actions are undertaken and by what means new knowledge is applied to improve theirs and other's practices, capacity building, best practice outcomes and standards. Additional benefits of participating in reflective practice include: recognising and continuing good practice; changing and improving what is not working well; challenging practices that are taken for granted; monitoring practice on an ongoing basis, and knowing when to find more information, and/or support from others (Pockett, Napier and Giles, 2013).

Creating time and regular opportunities to reflect and provide access to a mentor for continuing professional development are essential for promoting reflective practice (Raban et al., 2007; Jayatilleke and Mackie, 2013). The mentor who provides resources, skills and guidance to promote the development of effective reflective practice, challenges the professional's thinking and encourages them to look at things from multiple perspectives rather than reinforcing and affirming old habits (Kinsella, 2009; Brewer, 2016).

12.5 Mentoring

Mentoring is a voluntary, long-term, multifaceted developmental relationship where personal, psychosocial support and career guidance is provided to the mentee by a more experienced person/s (Brewer, 2016; Groves, 2007; MCEECDYA, 2014; UNSW, 2015). This supportive association seeks a more personal connection than other educational relationships. The mentoring relationship is established through mutual identification or attraction, and assists with career development and guides the mentee through the organisational, social and political networks (Booker, 2011; Brewer, 2016; Ehrich, 2013; MNHHS, 2015a and 2015b; Queensland Health, 2010).

Mentoring which is essentially initiated by a narrative (usually conveyed by the mentee), contributes to learning, improved critical thinking, analysis, understanding values, and outcomes aims to enhance self-awareness leading the mentee to gain confidence, and more effectively manage themselves in goals where they doubt capability (Bolman and Deal, 2008; Ehrich, 2013). Consequently, the focus is less on instruction, supervision and assessment of performance but rather on positively influencing the development and performance of the employee through role modelling, guidance and assisting with critical reflection (Brewer, 2016; Ehrich, 2013; MNHHS, 2015a and 2015b; Queensland Health, 2010).

Typically, the relationship involves an experienced professional supporting a less experienced colleague. However, this does not mean that the mentee is always a novice nurse/midwife or leader. Successful mentoring is not only about experience and expertise; it's frequently about personal qualities and inter-personal skills (Brewer, 2016; Ehrich, 2013; MNHHS, 2015a). The characteristics of mentoring relationships include the ratio of power, mutual respect, support, skills in communications and ability to negotiate and conduct difficult conversations and work together to foster learning and achieve the self-direction, self-observation and self-motivation. Furthermore, elements of counselling, coaching and team building also comprise mentoring (Brewer, 2016; Ehrich, 2013). As such, training in team development is essential for effective mentoring as it generates a variety of views and fosters mutual trust and transparency amongst team members and leaders (Ehrich, 2013; SSSC, 2014).

Therefore, mentoring not only benefits the mentee but the mentor as well by helping the mentor explore their own learning and development by cultivating inter-personal skills, leadership qualities and empathy. Moreover, supporting a colleague as their mentor requires one to question assumptions, develop new perspectives, and gain new knowledge and insights about yourself the profession and organisation (Brewer, 2016; Ehrich, 2013; SSSC, 2014).

Standards for Mentoring

Mentoring is established, maintained and supported as per HHS, facility/directorate/service process to promote capacity building, nurse/midwifery career development (Brewer, 2016; Ehrich, 2013; SSSC, 2014).

Please refer to relevant specific HHS/facility/directorate/service Mentoring Frameworks and teaching and learning resources when implementing, support and maintaining mentoring processes and standards (e.g. Association of Queensland Nursing and Midwifery Leaders (AQNML) Mentoring Framework and Toolkit) (AQNML, 2013).

Standards for Mentoring

- Nursing/midwifery governance sponsors mentoring for nurse/midwives via the application of pre-determined processes, frameworks and other resources.
- Nursing/midwifery governance determines a means for matching mentors and mentees as per specific HHS, facility/directorate/service processes. (Brewer, 2016; Groves, 2007; Heartfield, Gibson, Chestman and Tagg, 2005; MNHHS, 2015a; SSSC, 2014).
- Nursing/midwifery colleagues undertaking a mentor role are provided training opportunities.
- The development and tracking of a pool of suitably trained and prepared mentors occurs as per endorsed HHS/facility/directorate/service processes (Brewer, 2016; MNHHS, 2015a and 2015b; SSSC, 2014).
- The mentoring relationship is founded on intentional learning whereby the mentor assists through instructing, coaching, providing experiences, modelling and advising (Brewer, 2016; Ehrich, 2013; SSSC, 2014).

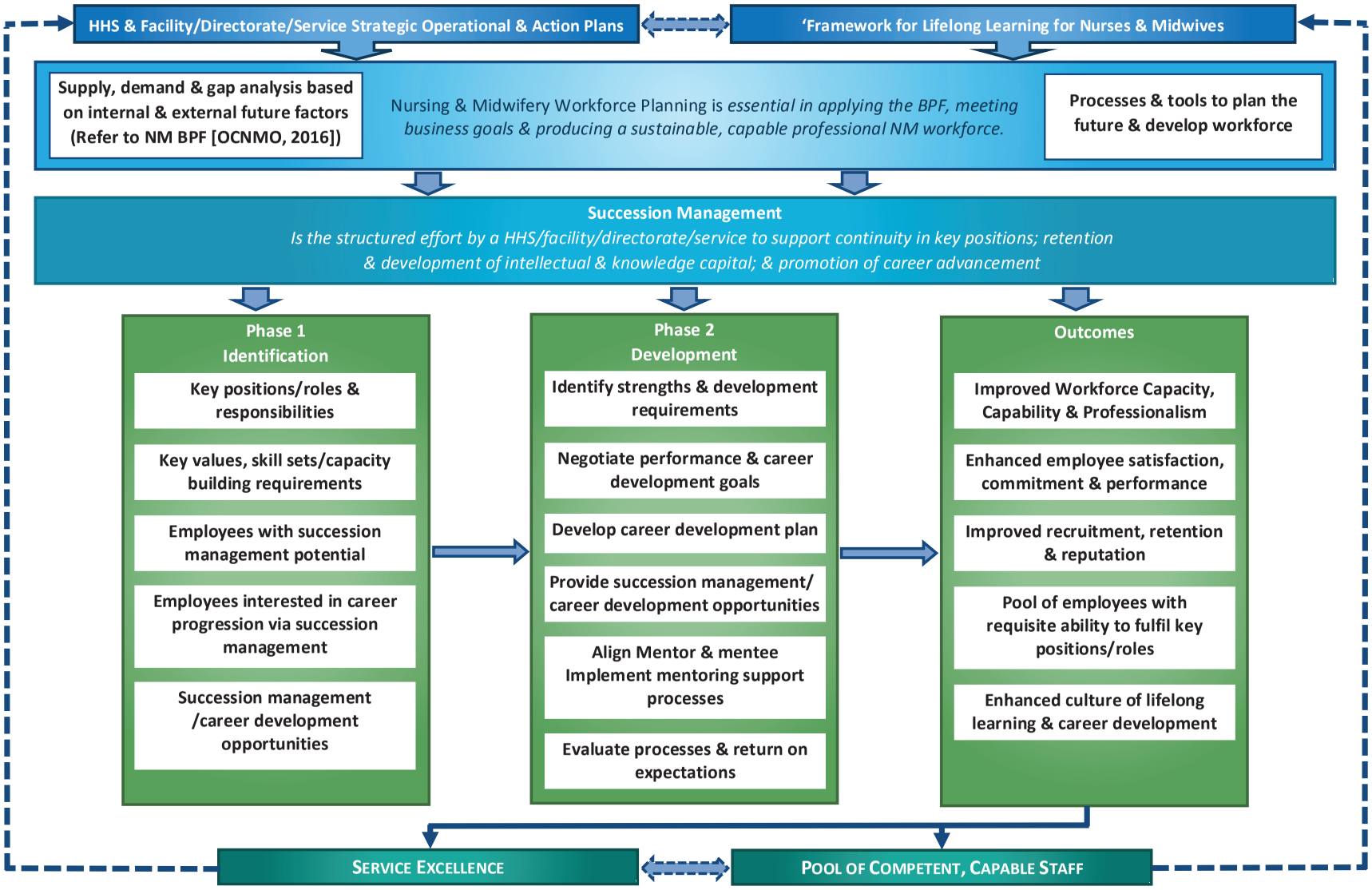
- Line Managers and Nurse/Midwifery Educators promote mentorship and facilitate opportunities for the mentor and mentee to participate in the mentoring relationship/discussions (Brewer, 2016; Ehrich, 2013; MNHHS, 2015a; SSSC, 2014).
- Line Managers provide feedback to the mentee and mentor (as appropriate) regarding the changes they have observed in the mentee and their performance (Brewer, 2016; Ehrich, 2013; MNHHS, 2015a; SSSC, 2014).
- Mentor training, support, development and feedback processes are evaluated and modified to improve return on expectations.

Mentoring can contribute to the engagement, motivation, morale, well-being, career mobility, and leadership capacity of mentees and mentors and organisational impact (Brewer, 2016; SSSC, 2014). It can also be an effective strategy for enriching succession management. Mentors paired with individuals being succession managed will complement succession planning goals and facilitate capacity. Additionally, experienced employee expertise will not be lost once they retire or leave the organisation but be retained through being shared by those who are poised to take their place (Ehrich, 2013; SSSC, 2014).

12.6 Succession Management

Succession Management, a component of workforce planning, aligns strategies to facilitate the continued effective performance of an individual or group by enabling the development, replacement and strategic application of key people over time (Aon Hewitt, 2012; Deloitte, 2016; Higginbottom, 2014; Rothwell, 2010). Fundamentally, succession management involves an integrated, systematic approach for identifying, developing, and retaining capable and skilled employees in line with current and projected organisational objectives. Succession management is a committed approach whereby organisations do not merely replace employees in critical positions as vacancies arise, but rather implement strategic, systematic and deliberate activities to facilitate future capability and success (Bersin by Deloitte, 2014; CPS HR Consulting, 2017; Innovation and Growth, 2012; Underhill, 2017). It also encourages individual career development and advancement with a focus on availability, and sustainability of a supply of a pool of nurse/midwives with the skills, knowledge and attitudes to become competent clinicians, managers, educators, researchers and leaders (CPS HR Consulting, 2017; Higginbottom, 2014; Innovation and Growth, 2012; Rothwell, 2010; Underhill, 2017).

Figure 8: Diagrammatic Representation of Succession Management



Adapted from Innovation & Growth (2012).

Organisations with sophisticated processes (e.g. Succession Management Framework/ Plans) for identifying successor candidates to fill key leadership or other crucial roles in an organisation realise significant improvement in employee engagement and career development and retention gains (Bersin by Deloitte, 2014; CPS HR Consulting, 2017; Higginbottom, 2014).

Standards for Succession Management

Succession Management strategies are utilised to foster the career development of individual nurses/midwives, attain and maintain a sustainable workforce, and assist in achieving organisational goals (CPS HR Consulting, 2017; Higginbottom, 2014; Underhill, 2017).

Standards for Succession Management

- Nursing/Midwifery governance apply succession management principles in striving for a pool of talented staff who can add value to a diverse, professional and capable workforce (Aon Hewitt, 2012; Deloitte, 2016; Higginbottom, 2014; Underhill, 2017).
- Succession management is applied appropriately as an essential strategy for future organisational success, capacity building, retention, recruitment, and career development (CPS HR Consulting, 2017; Higginbottom, 2014; Rothwell, 2010; Underhill, 2017).
- HHS, facilities/directorate/services demonstrate commitment to developing, assigning and promoting nurses/midwives via both internal and external career development opportunities and talent pool recognition (Aon Hewitt, 2012; Deloitte, 2016; Underhill, 2017).
- Line Managers are responsible for open and honest discussions with employees about development needs, succession management potential, opportunities and possible barriers to achievement of succession management and career development goals (Aon Hewitt, 2012; MNHHS, 2015a and 2015b; Queensland Health, 2013b and 2014b; Underhill, 2017).
- Succession management is an integral part of the facility/directorate/service/unit's business strategy and is linked to an employee's PDP (Aon Hewitt, 2012; CPS HR Consulting, 2017; Deloitte, 2016; MNHHS, 2015a and 2015b; Queensland Health, 2013b and 2014b).
- Employees are encouraged to participate in self-assessment of skills, values, interests and development needs to inform (as relevant) succession management plans (Aon Hewitt, 2012; CPS HR Consulting, 2017; MNHHS, 2015a and 2015b; Queensland Health, 2013b and 2014b).

To achieve effective supporting relationships, it important that underpinning support systems such as (however not limited to) PDP and Advanced Standing/Recognition of Prior Learning (RPL) are in place.

13. Underpinning Support Systems

Numerous support systems exist that promote staff engagement, opportunities to develop and measure performance outcomes, recognise previous experiences and provide a mechanism for evaluating and reporting actions, programs and key performance indicators. The content within this section offers insight into two (2) underpinning support systems that apply directly or indirectly to nursing/midwifery services and education supporting infrastructure.

13.1 Performance and Development Planning (PDP)

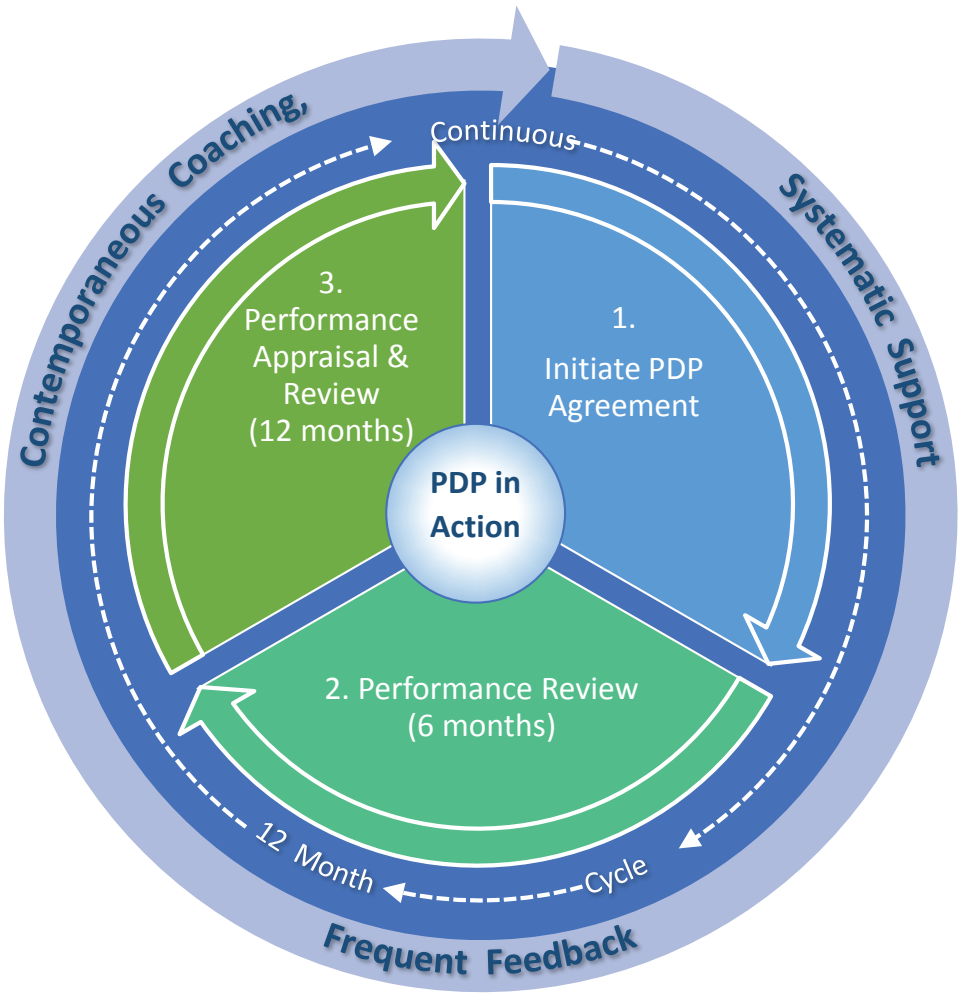
Performance and Development Planning (PDP) provides a valuable opportunity for nurses/midwives and respective line managers to discuss and plan for an individual's development with consideration of clinical, professional, organisational, current goals, outcomes, and individual future needs (Liverpool John Moores University [LJMU], 2015; Massey University, 2017; Queensland Health, 2017e and 2018c). This process enables each individual to appreciate work standards, values, acceptable behaviours, and return on expectations. PDP should also focus on mutual individual and manager responsibilities, development, career and succession management opportunities (LJMU, 2015; Massey University, 2017; Queensland Health, 2017e and 2018c).

The PDP system which applies to all employees provides line managers opportunity meet with staff to discuss expectations, review work practices, resolve performance concerns, recognise individual contributions and motivate and support individual and team collaboration (Queensland Health, 2017e and 2018c; SuccessFactors, 2018).

The PDP system operates as a continuous twelve-month cycle and all facets of an active PDP are of equal value (as represented in ***Figure 9***). However, application of the concepts of outer circle (coaching, support, feedback) are integral in effectively promoting communication, providing useful feedback about job performance, facilitating better working relationships and contributing to professional development throughout the process of the three identified stages (Queensland Health, 2017e and 2018c).

The responsibilities of the relevant position should be clearly articulated with the nurse/midwife on commencement of employment, and at the commencement of each new PDP cycle (Massey University, 2017; Queensland Health, 2017e). The content of the PDP Agreement should reflect clear timelines, performance objectives intended to reflect workplace priorities, team and organisational plans as well as a focus on continued improvement and career development. Nursing/midwifery PDP Agreements should be based on the individual's role description, Award classification, generic level statements, values and professional standards/competency expectations from an individual and organisational perspective (Massey University, 2017; (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]; Queensland Health, 2017e).

Figure 9: Performance and Development Planning (PDP) Cycle



Adapted from Queensland Health, 2017e, 2018c and 2018d

The PDP system is not applied punitively but rather is a negotiated supportive process to assist the nurse/midwife to feel confident about the work they perform. It also facilitates capability to manage and promote ongoing career planning, and continuing professional development in accordance with due process, fair procedures and natural justice (Queensland Health, 2017e and 2018c; SuccessFactors, 2018).

The role of the Nurse/Midwifery Educator in the PDP process is to provide support for line managers by assisting with motivating, coaching and planning professional development for individuals and teams, and providing support for staff to enact PDP principles to achieve role and professional expectations (Queensland Health, 2017e; SuccessFactors, 2018). Line managers and Nurse/Midwifery Educators working collaboratively assists with: evaluation of employee work behaviour; building on employee strengths, and identifying areas for improvement (Queensland Health, 2017e; Sydney Local Health District [SLHD], 2017).

Standards for PDP

All nurses/midwives actively participate in annual PDP (Queensland Health, 2017e and 2018c).

Standards for PDP

- Role descriptions that provide nurses/midwives with defined explanations of classification, autonomy and expectations, values, work responsibilities, knowledge, skills, professional standards/competencies and aligned standards of performance are used to support PDP processes (LJMU, 2015; Massey University, 2017; Queensland Health, 2017e and 2018c).
- The PDP process is used to establish and clarify expectations, and encourage continuing professional development, career planning, and succession management of nurses/midwives (LJMU, 2015; Massey University, 2017; Queensland Health, 2017e and 2018c).
- HHS, facility/directorate/service PDP processes are contextualised and applied to foster nursing/midwifery performance outcomes.
- Appropriate application of the PDP process is undertaken as a mechanism that assists nurses/midwives to receive, act on feedback, and further develop capabilities (Queensland Health, 2017e and 2018c; SuccessFactors, 2018).
- Regular PDP two-way conversations and a review of plans are used to resolve issues, and provide timely feedback to minimise the need to escalate to performance improvement processes (Queensland Health, 2017e, 2017f and 2018c; SuccessFactors, 2018).
- Informal but regular discussions throughout the year are used to enhance both parties ongoing commitment to objectives and rate of progress being achieved. Regular discussions are used for planning modification and identification of issues of difference or concern by either party at any stage of the annual cycle (Queensland Health, 2017e, 2017f and 2018c; SuccessFactors, 2018).
- Each nurse/midwife/Assistant in Nursing (AIN) is accountable for their standard of practice, and is expected to take an active role in PDP (Queensland Health, 2017e, 2017f and 2018c).
- Each line manager maintains a documented record of observations, outcomes of discussions and any other evidence to support positive feedback, assessment, addressing of concerns, and ongoing development of the nurse/midwife (Queensland Health, 2017e, 2017f and 2018c; SLHD, 2017).
- • Line managers use the PDP process as one means of encouraging reflective practice, celebrating performance achievements and supporting a culture of value, appreciation and lifelong learning (Queensland Health, 2017e, 2017f and 2018c; SuccessFactors, 2018).

13.2 Advanced Standing/Recognition of Prior Learning (RPL)

Any nurse/midwife can apply for consideration of *Advanced Standing* which is the recognition of prior learning (RPL) in terms of experience and/or studies (e.g. formal study, partial and professional experience). An RPL application in respect to organisational requirements (e.g. Preceptor training, Advanced Life Support, (PROMPT) must align to HHS/facility/directorate/service endorsed processes. Ability to grant RPL for a CPD is based on evidence provided of prior, and relevant successful completion of the core tenets of a specific program.

When an application for RPL is made, the applicant's prior learning is assessed and determined in respect to eligibility to be awarded *Advanced Standing* in either a CPD program or HES course in which they are enrolling, or are currently studying in recognition of previous achievements. This means that once

advanced standing is given, there is no longer the requirement complete the CPD and/or to study the units of learning of a course (QUT, 2015a and 2015b). HES providers may also refer to *Advanced Standing* as RPL, Credit Transfer (QUT, 2015a and 2015b) or Partial Credit.

Advanced Standing may be granted for a specified unit or units where prior learning is regarded as having satisfied both the objectives and the assessment requirements of the unit. Accordingly, recognition of prior learning may have been gained through previous study which has already been assessed by an educational establishment (e.g. university or TAFE) (QUT, 2015a and 2015b).

Additionally, *Advanced Standing* may be granted through recognising a number of credit points rather than a specific unit, where evidence of prior learning is regarded as consistent with the broad outcomes of a subject/unit or course/program. This prior learning may have been gained through work-based and/or life experience, self-tuition, non-accredited professional development programs, TAFE or university programs (QUT, 2015a and 2015b).

Nurses/midwives who successfully complete a TSP , and/or an Immersion (e.g. SWIM), or Accelerated Specialisation Program may elect to apply for credit/advanced standing for a post graduate course of study or part thereof as a result of individual learnings or credit arrangements. These arrangements may be negotiated by nursing/midwifery services and/or as per HHS/facility/ directorate/service processes with a number of the HES providers.

Please be aware that application requirements vary and that the nurse/midwife should be referred to the Higher Education Sector provider's specific requirements for the intended program/course of study.

While attainment of a post graduate award is not the primary intent of clinical, professional and/or organisational learning, nurses/midwives are strongly encouraged to use these learnings and experiences to advance professional and career prospects. This can be realised by completing a post graduate program of study which broadens knowledge, skills, professional perspective and strengthens contribution to best practice outcomes. Subsequent professional and HHS/facility/service benefits of a highly qualified and motivated workforce include, but are not limited to:

- Improved consumer outcomes through enhanced ability to attain service delivery requirements.
- The recruitment and retention of suitably skilled and qualified nurses/midwives.
- Provision of a safe competent nursing/midwifery workforce.
- Clinical capacity building and capability.
- An increase in the levels of nursing/midwifery satisfaction in relation to access to work-based clinical education.
- Increased numbers of nurses/midwives with post graduate qualifications (Gifford and Yarlagadda, 2018; Noland, 2018; OCNMO, 2013a and 2013b).

Consequently, while not a mandated requirement, it is highly desirable that nurses/midwives explore a suitable program of study in line with the AQF level eight (Graduate Certificate or Diploma) to ten (Doctoral Degree) to facilitate achievement of role and professional expectations (AQF, 2013; MNHHS, 2017b; OCNMO, 2014). Moreover, the graduate outcomes of the chosen program of study should be aligned and incorporated to practice to further facilitate career pathway progression (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]) (Refer to ***Section 8.2.1: Career Pathways***).

The benefits of study related to the profession include (but are not limited to):

- Learning immediately applicable to professional practice.
- Acquiring a broader, more questioning approach to responsibilities; the care provided is more likely to be research based and contribute to improvements in clinical care to achieve best practice standards.
- Being taught how to use the latest evidence to inform clinical decision making, giving confidence to work as a leader in a range of healthcare settings.

- Potential change in behaviour and expectations for own practice which assists to be better equipped to support new graduate entry to the professions.
- Changes in attitudes towards education and practice, and their perception that they are more capable to challenge practice, new knowledge, and skills (Ng, Tuckett, Fox-Young and Kain, 2014; Ng, 2016).

Accordingly, given potential professional, personal and organisational benefits nurses/midwives should be encouraged to undertake post graduate courses of study, and where applicable provide evidence that supports application for RPL of previous achievements.

14. Evaluation and Reporting

Investment in training and development is important to build capacity, capability, competitive advantage and professional reputation. The significant investment in education and training budgets and the need to demonstrate the value of programs is the fundamental motive for evaluating training programs, and the attempt to capture return on training expectations (Hayes et al., 2016; Kirkpatrick and Kirkpatrick, 2016; Paull, Whitsed and Girardi, 2016). However, before evaluation of training is undertaken it is imperative that the evaluation is well designed as it requires the sizeable commitment of financial resources and most existing training evaluation relies on the use of subjective information in the measurement of effort (Kirkpatrick and Kirkpatrick, 2016; Paull, Whitsed and Girardi, 2016). Evaluating the impact and effectiveness of an organisation's training and development investment is complex and is often not attempted given the results are frequently subjective and not easily quantified in respect to return on expectations and investment (Hayes et al., 2016; Kirkpatrick and Kirkpatrick, 2016).

To indicate the value of education in health care data captured and reported should highlight perceived, and outcome impacts of education programs and services from a variety of perspectives including, legislative compliance, participants, educators, line mangers, standards and patient care outcomes. As such, consultation needs to occur when gathering and analysing evidence and completing reports. Data reported should align with political, HHS and professional priorities and flow from education plans and self-assessment processes (Hayes et al., 2016; Kirkpatrick and Kirkpatrick, 2016). Therefore, the majority of nursing/midwifery education data will usually be captured and reported by Nurse/Midwifery Educators or delegates through established HHS/facility/ directorate/ service governance structures. Intrinsically Nurse/Midwifery Educators/ delegates fulfil a fundamental role in program, unit, module and workshop evaluation with the production of timely, relevant, credible, and objective findings and outcomes through evaluation methodologies and reporting.

14.1 Evaluation

Evaluation can be viewed as the process of appraising aspects of educational practices and activities for the purpose of demonstrating effectiveness, measuring and marketing performance (Kippers, Poortman, Schildkamp and Visscher, 2018). Additionally, evaluation is used by Nurse/Midwifery Educators (or delegates) as a professional activity that facilitates review and enhancement of learning requirements, strategies and interactions (Kippers et al., 2018). Nurse/Midwifery Educators should question the purpose of training, determine expected outcomes, align the training to needs and provide evidence that desired outcomes are achieved. This can be supported by implementing effective evaluation strategies that demonstrate organisational value of the training. Therefore, evaluation methods should be based on diverse, valid, and reliable data collection, analysis, and relevance of content to best practice care, and patient outcomes (Hayes et al., 2016; Kippers et al., 2018; Kirkpatrick and Kirkpatrick, 2016).

Prior to commencing any form of evaluation consideration is to be given to the following:

- Intent of the evaluation purpose (e.g. reason)
- Current situation
- Required information
- Provision of appropriate quality and quantity of data
- Appropriateness to the educational context
- Cost effectiveness (Kirkpatrick and Kirkpatrick, 2016; Shuffler, Salas and Xavier, 2010).

Hence, a model is usually applied when undertaking evaluation to support decisions regarding costs, benefits, and subsequent continuation, termination or modification of a program (Reio Jr., Rocco, Smith and Chang, 2017). As such, to facilitate consistency *Kirkpatrick's Evaluation Model* (Kirkpatrick and Kirkpatrick, 2016; Paull, Whitsed and Girardi,

2016) is provided as a useful taxonomy for evaluation of training programs. This model (Kirkpatrick and Kirkpatrick, 2016; Paull, Whitsed and Girardi, 2016) portrays four (4) levels of evaluation with each level applied sequentially to the measurement and evaluation of training from an individual and organisational performance level.

Level 1. *(Reaction)* – The extent to which a participant finds training beneficial, engaging and relevant to their position (e.g. participant satisfaction).

Level 2. *(Learning)* – The degree to which a participant acquires the intended knowledge, skills, attitude, confidence and commitment based on their involvement in training and/or intervention (e.g. what was learnt and how was it applied to their role).

Level 3. *(Behaviour)* – The scale of participant application of learning from training on return to the work environment (e.g. changes in behaviour applied positively to workplace/role).

Level 4. *(Results)* – The magnitude to which targeted outcomes and behaviours occur as a result of training and or intervention given relevant support (e.g. were the aims achieved as a result of the training/intervention and subsequent reinforcement i.e. return on expectations). This level includes consideration of perceptual (facility/ service benefits - attitudes and initiatives); performance (measurable improvements, increased efficiencies, absenteeism reductions); and financial costs and benefits results. (Kirkpatrick and Kirkpatrick, 2016; Paull, Whitsed and Girardi, 2016).

However, this is just one model which can be used in the process of evaluating training and the subsequent success of a program and is considered by some scholars to be limited as they view it as only focusing on what occurs after training rather than the entire process (Hayes et al., 2016; Kippers et al., 2018; Paradise and Patel, 2009). Nonetheless, the literature indicates that the majority of evaluation models are generally based on the four levels of Kirkpatrick's Evalaution Model which is still extensively used internationally (Paradise and Patel, 2009; Reio, 2010; Reio et al., 2017). Reio et al. (2017) contend that the strength of this model is in its simplicity, and ease of appreciating the concepts of training evaluation.

In undertaking evaluation of an individual (commonly referred to as assessment), it is important that a model such as Kirkpatrick (Kirkpatrick and Kirkpatrick, 2016) is also used, and that the tool/s applied is/are either based on salient criteria and/or competence (knowledge, skills, behaviours/abilities) to be demonstrated rather than a simple list of tasks. Competency assessment or criterion reference tools need to be validated, reliable and feasible and must itemise performance into identifiable and quantitative components which are clearly defined, measurable and observable (Gravells, 2016).

Moreover, whatever evaluation model is utilised (dependent on HHS/facility/directorate/service requirements/processes), the primary goal is to consider and synthesise the findings and develop recommendations for stakeholder application. (Office of the Chief Economist, 2015; Reio et al., 2017). Therefore, as Nurse/ Midwifery Educators/delegates are primarily responsible for summating, providing evaluation findings and recommendations, the subsequent reporting processes are critical in offering the foundation for decision making related to education resources, training programs and future direction (Office of the Chief Economist (OCE), 2015; Reio et al., 2017).

When developing an evaluation report, components required include (but are not limited to): target audience; engagement of stakeholders; purpose of evaluation; methodology; key findings; recommendations; lessons learnt (OCE, 2015; Kippers et al., 2018). Once the report is developed and reviewed it is submitted to relevant committees, line managers and other stakeholders, as per governance processes. Post endorsement recommendations and application of program improvements are undertaken with outcomes feedback via usual processes (OCE, 2015; Kippers et al., 2018). In

instances where evaluation data indicates nil modifications required via reflection-in-action, a summarised report (e.g. mean score) of the completed participant evaluation tools may be suitable to reflect participant satisfaction with the teaching strategies, the learning environment, and content in respect to meeting learning needs (Hayes et al., 2016; Kippers et al., 2018; Kirkpatrick and Kirkpatrick, 2016).

14.2 Reporting

Nursing/midwifery education services acknowledge the benefits of reporting training outcomes, targets, key performance indicators and reflection in action strategies as means for; demonstrating commitment to ongoing evaluation; enhancing optimisation of education processes; and capturing service consumer satisfaction.

To effectively report and communicate key performance indicators, and outcomes reports should include the following concepts: clear straightforward presentation of data and information; analysis of data (e.g. trends, statistics, benchmarks and targets); explanation to guide reader interpretation (e.g. demographics, indicators, methods, actions clear conclusions); and recommendations (e.g. suggestions or actions about how to change practice, actions or raise awareness).

Additionally, the use of graphs and tables is suggested as an effective approach to present complex data with clarity (HSPA, 2017). When disseminating a report consideration should be given to the timeliness, communication strategy, target audience and their readiness to accept and act. Monitoring and evaluation is important however, can only be reported meaningfully if there are clear, measurable and predetermined targets (HSPA, 2017).

Specifically, nursing/midwifery education reporting is significant as it provides the relevant staff with the ability to:

- Set internal and external benchmarks to improve performance.
- Measure and monitor workforce development capacity and capability.
- Demonstrate legislative, mandatory and requisite skill acquisition and compliance.
- Support workforce development, CPD, ongoing lifelong learning and decision making.
- Improve communication and ability to engage others in education initiatives and partnerships that add value to nursing/midwifery profile and reputation.
- Market education priorities and provide clarity regarding clinical, professional and organisational education/training opportunities.
- Attract internal and external project/development funding for innovation, change and implementation.
- Implement and monitor submission outcomes, government, HHS and professional imperatives.
- Monitor quality improvement processes to enhance educational outcomes and mitigate risk.
- Demonstrate engagement in teaching, leadership, research and other scholarly activities to build capacity of Nurse/Midwifery Educators and others.
- Determine return on investment and expectations (Gravells, 2016; Kirkpatrick and Kirkpatrick, 2016).

An Education Plan aligned to relevant tenets of nursing/midwifery, BPF (OCNMO, 2016) principles and HHS Strategic Plans is an effective approach to formulate direction, identify priorities, key strategies, actions, responsibilities and key performance indicators. Performance outcomes monitored and evaluated through a comprehensive range of controls/metrics/targets to verify outputs/outcomes and reported through the nursing/midwifery governance structure as per HHS, Facility/directorate/service requirements. This form of reporting assists in gauging the effectiveness of education services in building a capable workforce and return on expectations.

Monitoring, evaluation and reporting is usually undertaken by Nurse/Midwifery Educators or delegates. The use of a standardised reporting

template with KPIs assists with data integrity, reporting consistency, and benchmarking. Production of a biannual or annual Education Outcomes Report is a useful summary of qualitative and quantitative data related to outcomes and performance against the KPIs for ongoing monitoring and priority setting for the next year. Effective dissemination of nursing/midwifery education reports to relevant stakeholders affords the service the opportunity to profile and market services and utilise feedback mechanisms to receive target audience comments and modify approaches as relevant to the HHS, facility/directorate/service.

15. Conclusion

As identified in the introduction The Framework offers a scaffold for all teaching and learning considerations that 'value add' to achieving a sustainable, professional, capable patient focused nursing/midwifery workforce that is respected for competence and quality. *Framework* sections and sub-sets focus on strategies, and standards to facilitate nursing/midwifery governance, Nurse/Midwifery Educators and others (e.g. nurse/midwifery unit and line managers) development of workforce capacity, capability, relationships, decision-making, and a positive culture of learning to facilitate the provision of safe person-focused outcomes within any context of health care.

Effective application of the tenets of the Framework provides Nurse/Midwifery Educators and others the opportunity to improve nursing/midwifery staff education and training experiences by informing strategies, policy, practices and behaviours aligned to strategic and operational imperatives. Nurse/Midwifery Educators (or delegates) take a lead role implementing strategies to support application; and standards to measure the effectiveness of educational activities and foster an environment conducive to workplace learning thus engendering a philosophy of lifelong learning.

16. Appendices

Appendix 1: Glossary

Term	Definition
Advanced Qualification	An *Advanced Qualification* is a Masters degree or PhD (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).
Australian Health Practitioner Regulation Agency (AHPRA)	The *Australian Health Practitioner Regulation Agency (AHPRA)* is the organisation responsible for the implementation of the ***National Registration and Accreditation Scheme*** across Australia.
Award	The achievement (e.g. certificate, diploma, degree, graduate certificate, graduate diploma, master's degree, professional doctorate or doctor of philosophy) – conferred upon successful completion of the requirements for that specified program (University of Adelaide, 2017).
Career	A process of development of the employee along a path of experience and jobs in one or more facility/services (McIlveen, 2009)
Career Development	The lifelong process of managing learning and work activities in order to live a productive and fulfilling life (Nova Scotia Public Service Commission, 2015).
Career Planning	Is the active, deliberate and tailored facilitation of an individual's career development through a process in which the individual is ultimately engaged (MNHHS, 2015a and 2015b).
Career Self-Management	Is an active process that consists of: • strategic individual behaviours (e.g. applying for a career-enhancing position, learning a new skill) or joint actions with another person (e.g. establishing a mentoring relationship), • behaviours which ensure positive influences among others (e.g. self-promotion), and • behaviours which balance the demands of roles and prevent transgression of boundaries (e.g. work-life balance) (Rothwell, 2010).
Clinical Learning	*Clinical learning* refers to the requisite knowledge, skills and attributes specified by the organisation as being essential to enable nursing and midwifery staff to demonstrate acceptable standards of practice in the delivery of patient care to achieve best practice outcomes.
Competence	*Competence* is the combination of knowledge, skills, attitudes, values and abilities that underpin effective performance in a profession (NMBA, 2007a).
Context	*Context* refers to the environment in which nursing/midwifery is practiced. It includes the: • patient/client characteristics and health needs and the complexity of care required by them • model of care, type of service or health facility and physical setting • amount of clinical support and/or supervision that is available • resources that are available, including the staff skill mix and level of access to other health care professionals (NMBA, 2007a).

Term	Definition
Continuing Professional Development (CPD)	*CPD* (often interchanged with the terms *Lifelong Learning* or *Continuing Professional Education*) is viewed as a long-term process that includes opportunities and experiences systematically planned to promote growth and development in the profession (NMBA, 2016; Fahey and Monaghan, 2005; Ganser, 2000; Morgan et al., 2008).
Credentialing	Credentialed practice comprises a formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of health professionals. Credentialing may be conducted by the organisation or a professional body. The purpose of *Credentialing* is to form a view of the individual's competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments.
Enrolled Nurse (EN)	An *Enrolled Nurse* is an employee who appears on the *Register of Practitioners of the Australian Health Practitioners Regulation Agency (AHPRA)* as an Enrolled Nurse Division 2 (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).
Expanding Scope of Practice	The NMBA supports decision-making for RNs/midwives, who are practicing at advanced levels and wish to expand their practice (NMBA, 2007). Expansion of the RN/midwife's practice occurs when they assume the responsibility to provide a new health care activity or service beyond what is viewed as the established, contemporary scope of practice (ANMF, 2014). Expanded scope of practice may include: • the use of new technology, i.e. laser treatment for cosmetic purposes; • the integration of complementary care, i.e. therapeutic massage, hypnotherapy, naturopathy; • shared activities with other health professionals to improve access to a skilled health workforce; • professional roles, i.e. Protocol Initiated X-rays (PIX), ultrasound therapy; and • changes in referral, diagnostic, prescribing and medication supply authorisations. Expanded practice comprises formal processes for continuing education, assessment of competence and authorisation through credentialing (NMBA, 2007; RNAO, 2014). *An EN cannot expand their Scope of Practice.*
Generic Level Statements (GLS)	Are broad, concise statements of the duties, skills and responsibilities indicative of a given nursing/midwifery classification level (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).
Induction	*Induction* is the process by which employees are familiarised with their new immediate work unit and environment, including local work practices, standards, safe work procedures, administrative procedures and training in relevant systems (Queensland Health, 2018).

Term	Definition
Knowledge Management and Transfer	A conscious strategy of transferring the right knowledge to the right people at the right time (Calo, 2008; Edwards, 2015).
Legislative Training	Training required to comply with legislation or acts (e.g. fire safety training).
Lifelong Learning	*Lifelong Learning* is the provision or use of both formal and informal learning opportunities throughout people's lives in order to foster the continuous development and improvement of the knowledge and skills needed for employment and personal fulfilment (Collins, 2018).
Mandatory Training	Training which has been identified by the HHS as mandatory / compulsory for staff in alignment with policy or required by relevant directive.
Midwife	A *Midwife* is an employee who appears on the Register of Practitioners of the Australian Health Practitioners Regulation Agency (AHPRA) as a Midwife (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).
Mentor	Someone who is recognised as a highly proficient professional who is selected by an individual to guide their development from both personal and professional perspectives (Huybrecht, Loeckx, Quaeyhaegens, De Tobel and Mistiaen, 2011; MNHHS, 2015a; Queensland Health, 2010).
Mentoring	*Mentoring* is a voluntary, long-term, multifaceted developmental relationship where personal, psychosocial support and career guidance is provided to the mentee by a more experienced person/s (Brewer, 2016; Groves, 2007; MCEECDYA, 2014; UNSW, 2015).
Nursing and Midwifery Board of Australia (NMBA)	The *Nursing and Midwifery Board of Australia (NMBA)* is the National Board under AHPRA for nursing and midwifery in Australia (NMBA, 2017).
Nursing/ Midwifery Education	*Nursing/Midwifery Education* consists of the theoretical learning and practical training provided to nurses/midwives with the purpose to prepare them for their duties, advance practice through specialisation, and respond to changing demands on the profession (Kalinski, 2014; Longe and Narins. 2017).
Work Unit Development Map	*A Work Unit Development Map* (e.g. of a learning pathway) summarises the key elements of development required by a nurse/midwife throughout the continuum of learning of their work life. The *Work Unit Development Map* can be contextualised to any work unit and can be applied at every stage of a nurse/midwife's career in relation to their role (e.g. AIN, EN, RN/Midwife, etc.) and developmental stage (e.g. new graduate, experienced RN/Midwife, or RN specialisation) to meet individual learning needs.
Operational Plan	*Operational Plans* are the link between strategic objectives, policy and directives and the implementation of activities. Operational Plans aim to transform the strategic-level plan into actionable tasks and include service standards and other measures that allow the HHS/facility/ directorate/service to assess performance in the delivery of services (Schmets, Rajan and Kadandale, 2016).

Term	Definition
Organisational Knowledge	*Organisational Knowledge* is the collective knowledge and abilities possessed by the people who belong to an organization. It is a distinct attribute of an organisation and is different and distinguishable from the knowledge of individuals (Spacey, 2017).
Organisational Learning	The knowledge and skills required by nurses and midwives to function effectively in their roles to achieve specific organisational aims (AHRI, 2015).
Orientation	*Orientation* is the process by which new employees are provided with the opportunity to gain knowledge and appreciation of the HHS, including its mission, strategic objectives, corporate initiatives and scope of the health service including facilities, services and specific legislative, mandatory and requisite training and assessment (Queensland Health, 2018).
Performance and Development Planning (PDP)	*PDP* is the process of identifying, evaluating and developing the performance of employees in a HHS/facility/directorate/service, so that organisational goals are more effectively achieved. It also provides the mechanism whereby all employees can benefit in terms of recognition, receiving feedback, career planning and professional and personal development (Queensland Health, 2013b and 2014b).
Preceptor	A *Preceptor* is a competent, confident and experienced practitioner who facilitates the effective transition and assimilation of a newly registered or transferred nurse/midwife to the work environment through role modelling; demonstration of supportive behaviours; identifying and addressing learning needs; and guiding practice and development (Trede, Sutton and Bernoth, 2015; Valizadeh et al., 2016).
Preceptorship	*Preceptorship* is a formal, preplanned relationship between an experienced and newly registered/transferred nurse/midwife during which he/she is transitioned to the work environment; supported to develop their competence and confidence as an autonomous professional; refine their skills, values and behaviours; and continue their journey of life-long learning. (Valizadeh et al., 2016; Whitehead et al., 2015).
Registered Nurse (RN)	An *RN* is an employee who appears on the *Register of Practitioners of the Australian Health Practitioners Regulation Agency (AHPRA)* as a Registered Nurse Division 1 (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).
Requisite Training	Training required for specific groups of staff to enable them to perform their role to meet professional and local service requirements.
Specialised	*Specialised* refers to a more focused area of practice where the nurse/midwife works with a discrete patient/client group in a defined setting (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).
Specialist	*Specialist* means a nurse/midwife who is recognised for their breadth of knowledge or skill within their specialised area of practice (Nurses and Midwives [Queensland Health] Award – State 2015, [Reprinted 2017]).

Term	Definition
Students (Undergraduate, Post Graduate, Enrolled and Re-Entry)	Any nursing and/or midwifery student who is enrolled in a course or module of study with an Education Provider, or is an Externally Enrolled Scholar, and undertakes a Placement in accordance with the terms of Queensland Health Student Deed (***http://www.health.qld.gov.au/sop/2html/help_dng.asp***)
Succession Management	*Succession Management* is any effort designed to ensure the continued effective performance of a HHS/facility/service, division, department or work group by making provision for the development, replacement and strategic application of key people over time (Deloitte, 2016; Higginbottom, 2014; Victorian Public Sector Commission, 2015).
Training	*Training* is aimed at enhancing employees' personal qualities that lead to greater organisational efficiency and higher performance standards through assisting employees obtain knowledge and skills required for optimal performance and development within the areas relevant to the organisation.
Transition	*Transition* is the period of learning and adjustment in which the new staff member acquires the skills, knowledge and values required to become an effective member of the health care team (Fox, Henderson and Malko-Nyhan, 2005; MNHHS, 2015c; Queensland Health, 2011).
Transition Support Programs (TSPs), Immersion (e.g. SWIM) and/ or Accelerated Specialisation Programs	*TSPs, Immersion (e.g. SWIM) and/or Accelerated Specialisation Programs* are contemporary, post registration, clinically focused, continuing professional development programs. These programs developed for specific cohorts assist the newly graduated or transferred nurse/midwife to acquire further general and speciality knowledge and skills in a logical, sequenced supported approach to effectively transition to work expectations (Queensland Health, 2012).
Unlicensed health care workers	*Unlicensed health care workers* are not registered to practise as an RN, midwife or EN. They include, but are not limited to, AIN , Personal Care Workers, Indigenous Health Workers, Undergraduate Students in Nursing (USIN) and students undertaking a school-based traineeship. *Unlicensed health care workers* carry out routine, non-complex components of care that are delegated following risk assessment by an RN, midwife or other appropriate health professional (e.g. the Anaesthetic Technician is accountable to the Anaesthetist) (NMBA, 2007).
Upskilling	Any training or education that provides a participant with a new or additional knowledge or skills to enhance workforce capacity and capability (excludes Legislative, Mandatory or Requisite Skills)
Workforce Capability	*Workforce Capability* refers to the HHS/facility/service ability to accomplish its work processes through knowledge, skills, abilities and competencies of its people (APS, 2012).
Workforce Planning	*Workforce Planning* is the systematic identification and analysis of what an HHS/facility/service is going to need in terms of size, type and quality of workforce to achieve its objectives (APS, 2012).

Appendix 2: Examples of CPD Activities

Workplace Learning	Professional Activity
• Action learning • Coaching from others • Case studies/presentations • Clinical audit • Reflective practice • Self-assessment • Peer review and discussions with colleagues • Supervising staff or students • Involvement in wider-work of employer (e.g. participation in/representation on a committee) • Acting up • Work shadowing • Secondments/locums/job rotation • Site/department visits • Ward rounds • Journal club • Study groups/special interest groups • In-service training • Role expansion • Situational analysis of significant events • Project work or project management • Quality assurance activities • Developing pathways, protocols, guidelines, policy etc. • Participating in performance development	• Professional body membership • Organisation/participation in journal clubs or specialist interest group activities • Lecturing or teaching • Succession Management • Mentoring • Being a resource person and assessor • Attending branch meetings • Maintaining or developing specialist skills • Being an expert witness • Participating in or chairing a committee/ working party • Giving presentations at conferences • Undertaking individual assignments • Organising accredited courses • Supervising research • Clinical supervision of colleagues • ANMAC accreditation team member • ACN Community of Interest • Professional/career promotion
Self-Directed Learning	**Formal / Educational**
• Reading journals/articles • Conducting evidence-based reviews/ literature searches • Online discussion groups • Reviewing/editorial of books/articles/ professional documents • Contemporary professional reading through the Internet or TV • Keeping a file of progress	• Courses • Workshops • Further education • Undertaking research • Attending conferences • Writing articles or papers • Going to seminars • Distance learning/online learning • Courses accredited by professional body • Planning or running a course • Delivering training. Other • Public service • Voluntary work • Courses

(Adapted from Health and Care Professions Council [HCPC], 2017)

Appendix 3: Recommended AQF Levels for Nursing/Midwifery Classifications

AQF levels and the AQF levels criteria are an indication of the relative complexity and/or depth of achievement and the autonomy required to demonstrate that achievement. The AQF level summaries are statements of the typical achievement of graduates who have been awarded a qualification at a certain level in the AQF.

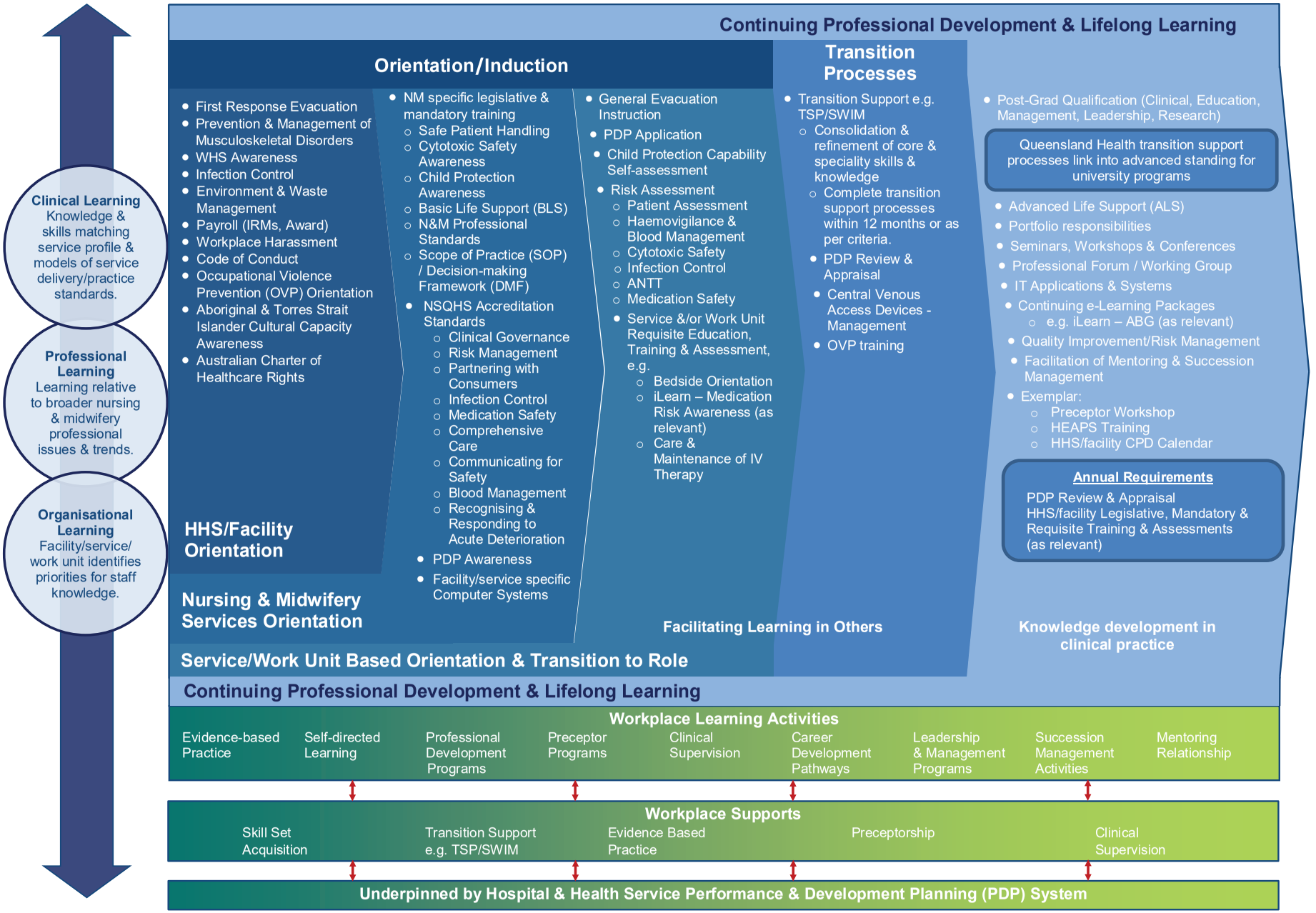
Nursing/Midwifery Classification	Recommended AQF Level	AQF Level Summary	AQF Qualification Type
Grade 1 Band 1 Assistant in Nursing	Completion of a suitable program of study at AQF Level 3 is desirable.	Graduates at this level will have theoretical and practical knowledge and skills for work and/or further learning.	Certificate III
Grade 1 Band 2 Assistant in Nursing (Sterilisation Services)			
Grade 3 Enrolled Nurse	Completion of a suitable program of study at AQF Level 5 is mandatory to facilitate achievement of role expectations. The graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	Graduates at this level will have specialised knowledge and skills for skilled/ paraprofessional work and/or further learning.	Diploma
Grade 4 Enrolled Nurse Advanced Skills	Completion of a suitable program of study at AQF Level 5 is mandatory. Additionally, it is highly desirable that an AQF Level 6 program is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	Graduates at this level will have broad knowledge and skills for paraprofessional/ highly skilled work and/or further learning.	Advanced Diploma Associate Degree
Grade 5 Registered Nurse/Midwife	It is required that a suitable program of study at AQF 7 is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	Graduates at this level will have broad and coherent knowledge and skills for professional work and/or further learning.	Bachelor Degree
Grade 6 Band 1 Clinical Nurse/Midwife	It is highly desirable that exploration of a suitable program of study at AQF level 8 is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	Graduates at this level will have advanced knowledge and skills for professional/highly skilled work and/or further learning.	Bachelor Honours Degree Post Graduate Certificate Graduate Diploma
Grade 6 Band 2 • Associate Clinical Nurse/Midwife Consultant • Associate Nurse/Midwife Unit Manager • Associate Nurse/Midwife Manager • Associate Nurse/Midwife Educator • Associate Nurse/Midwife Researcher			

Nursing/Midwifery Classification	Recommended AQF Level	AQF Level Summary	AQF Qualification Type
Grade 7 • Clinical Nurse/Midwifery Consultant • Nurse/Midwifery Educator • Nurse/Midwifery Unit Manager • Nurse/Midwifery Manager • Nurse/Midwifery Navigator • Project Manager • Nurse/Midwifery Researcher • Nurse/Midwifery Manager (Business Planning Framework)	It is highly desirable that exploration of a suitable program of study at AQF level 8 or AQF 9 level is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	AQF 8 graduates at this level will have advanced knowledge and skills for professional/highly skilled work and/or further learning. Graduates at this level will have specialised knowledge and skills for research, and/or professional practice and/or further learning	Post Graduate Diploma Masters Degree
Grade 8 Nurse Practitioner	AQF 9 level is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	Graduates at this level will have specialised knowledge and skills for research, and/or professional practice and/or further learning.	Masters Degree
Grade 9 Director of Nursing – Rural and/or Remote	It is highly desirable that exploration of a suitable program of study at AQF level 8 or AQF 9 level is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	AQF level 8 graduates at this level will have advanced knowledge and skills for professional/ highly skilled work and/or further learning. AQF level 9 graduates at this level will have specialised knowledge and skills for research, and/ or professional practice and/or further learning.	Post Graduate Diploma Masters Degree
Grade 10 Assistant Director of Nursing (ADON)	It is highly desirable that exploration of a suitable program of study at AQF level 8 or AQF 9 level is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	AQF level 8 graduates at this level will have advanced knowledge and skills for professional/ highly skilled work and/or further learning. AQF level 9 graduates at this level will have specialised knowledge and skills for research, and/ or professional practice and/or further learning.	Post Graduate Diploma Masters Degree

Nursing/Midwifery Classification	Recommended AQF Level	AQF Level Summary	AQF Qualification Type
Grade 11 Director of Nursing (Program or Portfolio)	It is highly desirable that exploration of a suitable program of study at AQF level 9 is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	AQF level 9 graduates at this level will have specialised knowledge and skills for research, and/or professional practice and/or further learning.	Masters Degree
Grade 12 Director of Nursing (Facility, Program or Portfolio) or Nursing Director	It is extremely desirable that a suitable program of study at AQF level 9 or AQF level 10 is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	AQF level 9 graduates at this level will have specialised knowledge and skills for research, and/or professional practice and/or further learning. AQF level 10 graduates at this level will have systematic and critical understanding of a complex field of learning and specialised research skills for the advancement of learning and/or for professional practice.	Masters Degree Doctoral Degree
Grade 13 Band 1 Health Service Director of Nursing or Executive Director of Nursing and Midwifery	It is extremely desirable that a suitable program of study at AQF level 9 or AQF level 10 is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	AQF level 9 graduates at this level will have specialised knowledge and skills for research, and/or professional practice and/or further learning. AQF level 10 graduates at this level will have systematic and critical understanding of a complex field of learning and specialised research skills for the advancement of learning and/or for professional practice.	Masters Degree Doctoral Degree
Grade 13 Band 2 Executive Director of Nursing and Midwifery	It is extremely desirable that a suitable program of study at AQF level 9 or AQF level 10 is undertaken to facilitate achievement of role expectations and graduate outcomes of the chosen program of study are incorporated and aligned to practice to further facilitate career pathway progression.	AQF level 9 graduates at this level will have specialised knowledge and skills for research, and/or professional practice and/or further learning. AQF level 10 graduates at this level will have systematic and critical understanding of a complex field of learning and specialised research skills for the advancement of learning and/or for professional practice.	Masters Degree Doctoral Degree

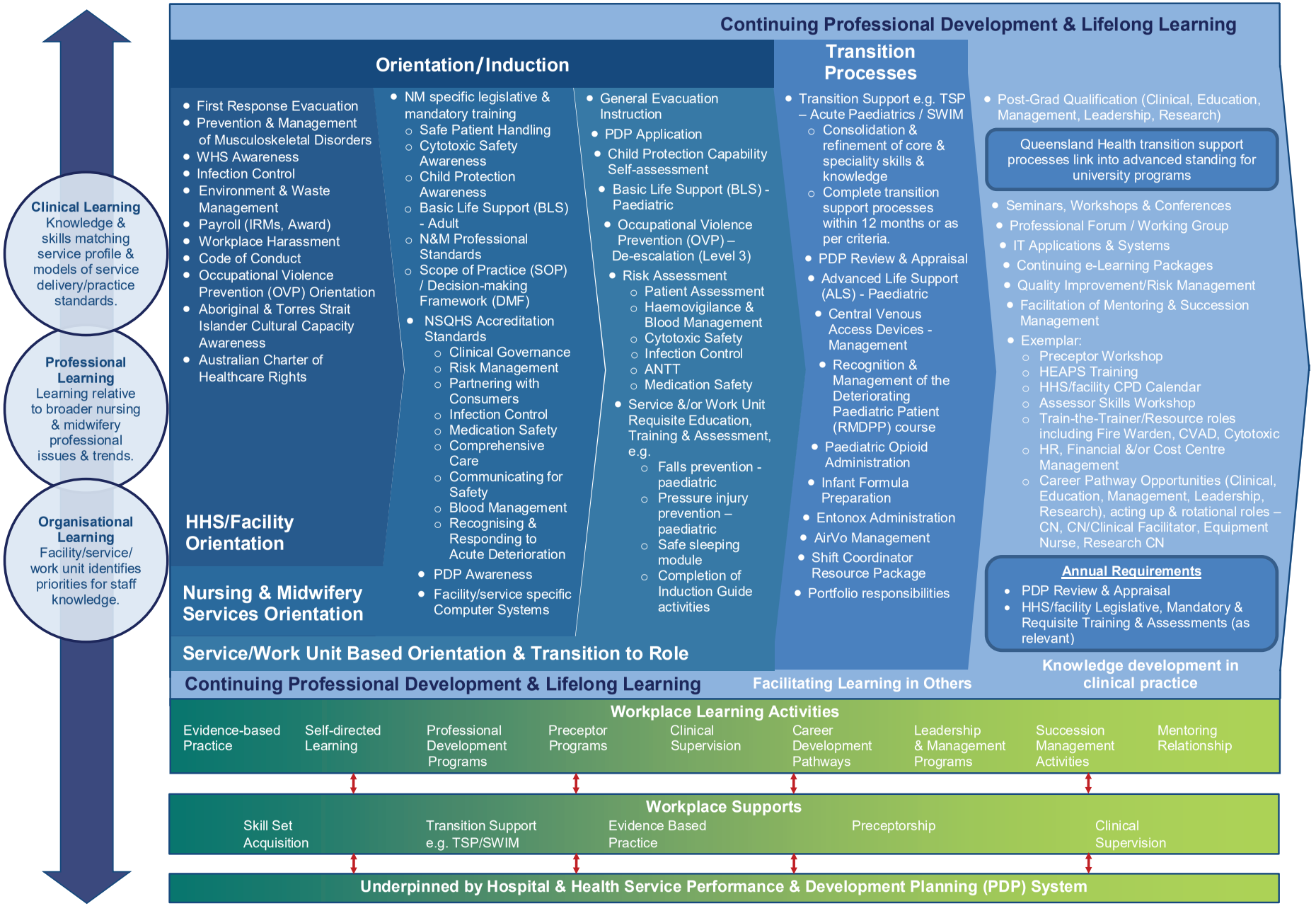
Appendix 4: Examples of Work Unit Development Maps

New Graduate



Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)

Paediatric Nurse



Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)

Perioperative Midwife

Clinical Learning
Knowledge & skills matching service profile & models of service delivery/practice standards.

Professional Learning
Learning relative to broader nursing & midwifery professional issues & trends.

Organisational Learning
Facility/service/ work unit identifies priorities for staff knowledge.

Continuing Professional Development & Lifelong Learning

Orientation/Induction

HHS/Facility Orientation

- First Response Evacuation
- Prevention & Management of Musculoskeletal Disorders
- WHS Awareness
- Infection Control
- Environment & Waste Management
- Payroll (IRMs, Award)
- Workplace Harassment
- Code of Conduct
- Occupational Violence Prevention (OVP) Orientation
- Aboriginal & Torres Strait Islander Cultural Capacity Awareness
- Australian Charter of Healthcare Rights

Nursing & Midwifery Services Orientation

- NM specific legislative & mandatory training
  - Safe Patient Handling
  - Cytotoxic Safety Awareness
  - Child Protection Awareness
  - Basic Life Support (BLS) - Adult
  - N&M Professional Standards
  - Scope of Practice (SOP) / Decision-making Framework (DMF)
- Accreditation Standards
  - Clinical Governance
  - Risk Management
  - Partnering with Consumers
  - Infection Control
  - Medication Safety
  - Comprehensive Care
  - Communicating for Safety
  - Blood Management
  - Recognising & Responding to Acute Deterioration
- PDP Awareness
- Facility/service specific Computer Systems

Service/Work Unit Based Orientation & Transition to Role

- General Evacuation Instruction
- PDP Application
- Child Protection Capability Self-assessment
- Basic Life Support (BLS) - Paediatric
- Risk Assessment
  - Patient Assessment
  - Haemovigilance & Blood Management
  - Cytotoxic Safety
  - Infection Control
  - ANTT
  - Medication Safety
- Service &/or Work Unit Requisite Education, Training & Assessment, e.g.
  - Neonatal Resuscitation
  - Radiation Safety
  - Perioperative Patient Handling
  - I-Stat
  - ORMIS
  - Clinical Handover

Transition Processes

- Transition Support e.g. TSP – Perioperative / SWIM
  - Consolidation & refinement of core & speciality skills & knowledge
  - Complete transition support processes within 12 months or as per criteria.
- PDP Review & Appraisal
- Care & Maintenance of IV Therapy
- Central Venous Access Devices - Management
- Shift Coordinator Resource Package
- Portfolio responsibilities

Continuing Professional Development & Lifelong Learning

- Post-Grad Qualification (Clinical, Education, Management, Leadership, Research)

Queensland Health transition support processes link into advanced standing for university programs

Facilitating Learning in Others

- Seminars, Workshops & Conferences
- Professional Forum / Working Group
- IT Applications & Systems
- Continuing e-Learning Packages
- Quality Improvement/Risk Management
- Facilitation of Mentoring & Succession Management
- Exemplar:
  - Preceptor Workshop
  - HEAPS Training
  - HHS/facility CPD Calendar
  - Assessor Skills Workshop
  - Train-the-Trainer/Resource roles including Fire Warden, CVAD, Cytotoxic
  - HR, Financial &/or Cost Centre Management
  - Career Pathway Opportunities (Clinical, Education, Management, Leadership, Research), acting up & rotational roles – CN, CN/Clinical Facilitator, Equipment Nurse, Research CN

Annual Requirements

- PDP Review & Appraisal
- HHS/facility Legislative, Mandatory & Requisite Training & Assessments (as relevant)

Knowledge development in clinical practice

Workplace Learning Activities

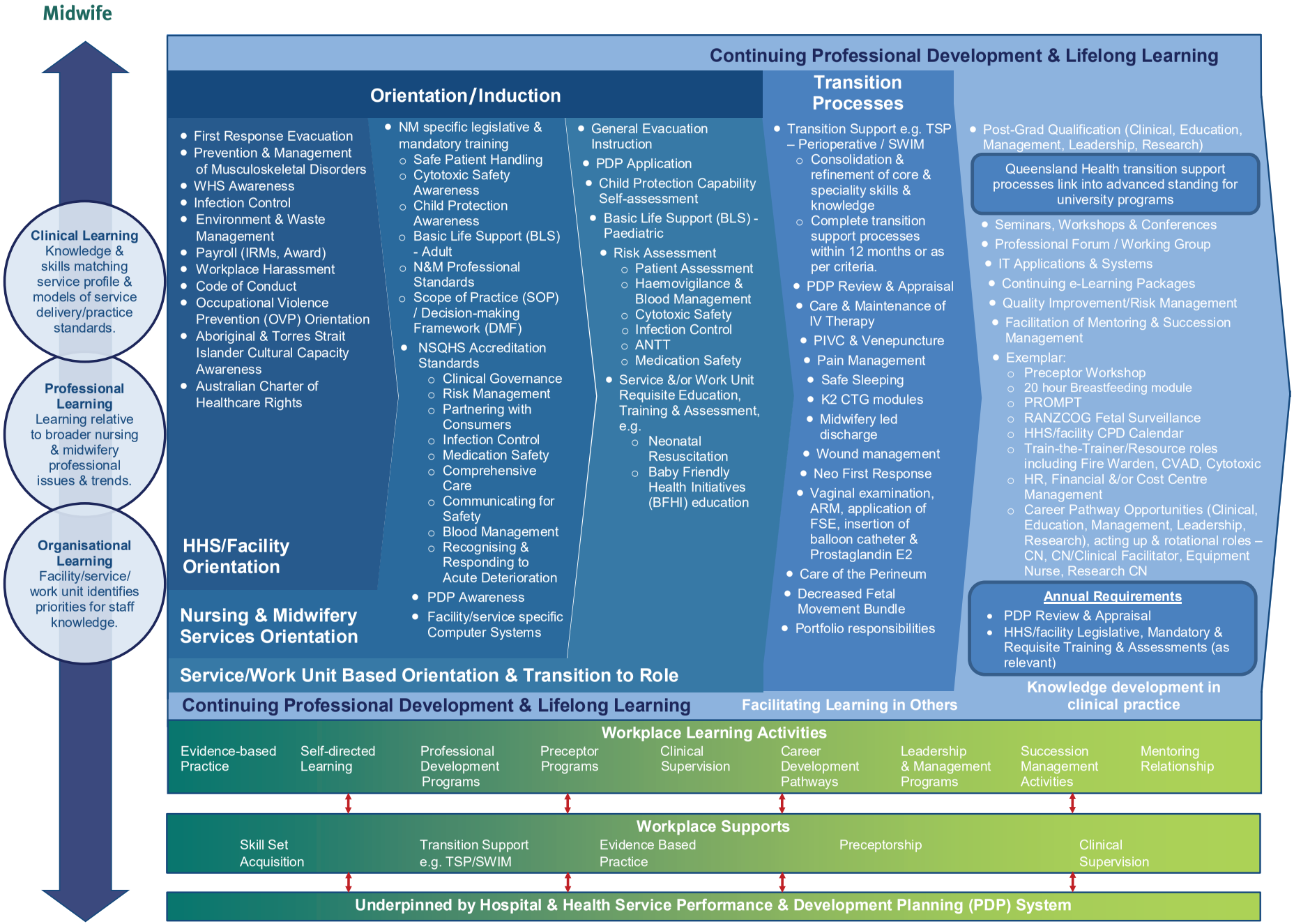
Evidence-based Practice | Self-directed Learning | Professional Development Programs | Preceptor Programs | Clinical Supervision | Career Development Pathways | Leadership & Management Programs | Succession Management Activities | Mentoring Relationship

Workplace Supports

Skill Set Acquisition | Transition Support e.g. TSP/SWIM | Evidence Based Practice | Preceptorship | Clinical Supervision

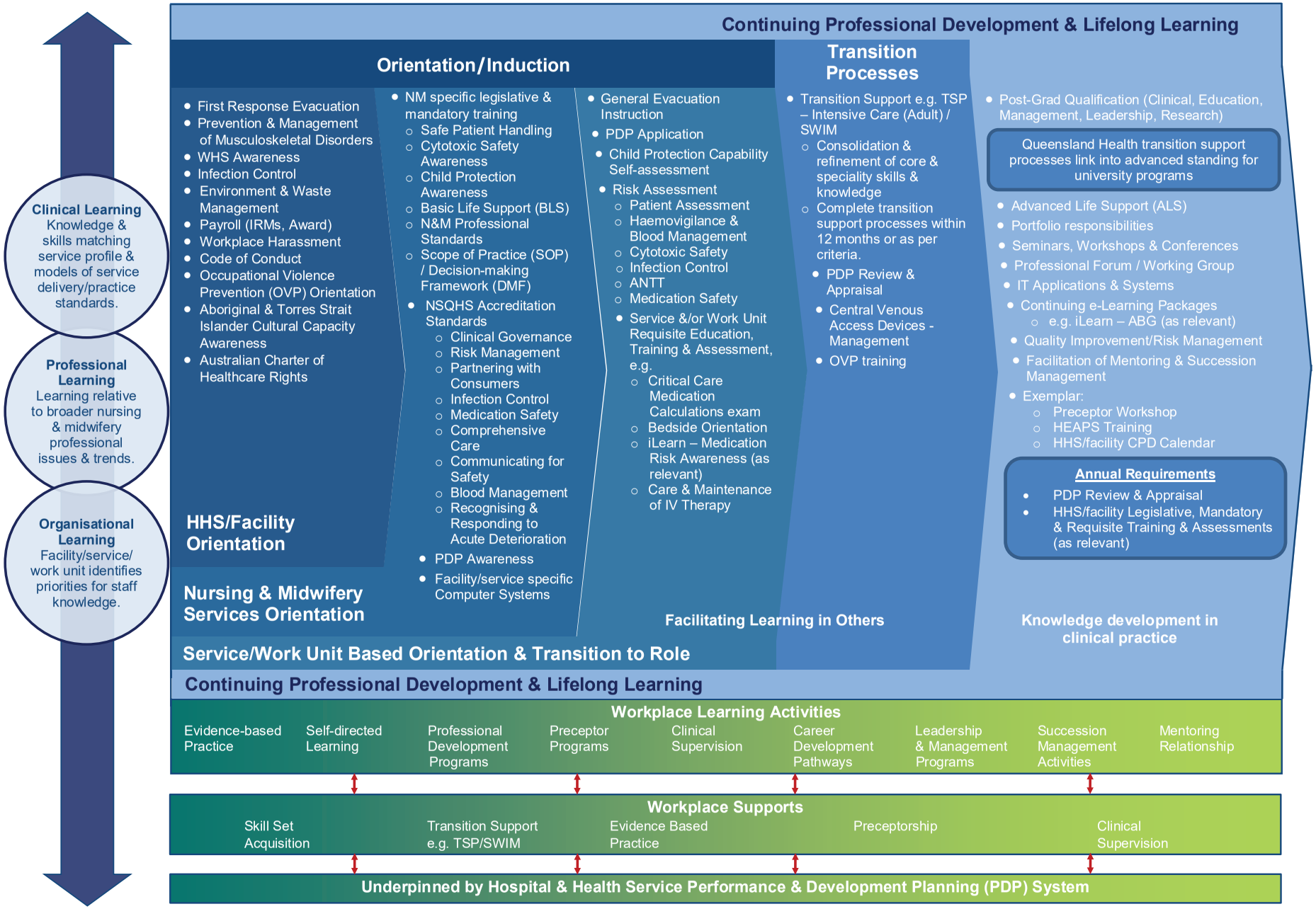
Underpinned by Hospital & Health Service Performance & Development Planning (PDP) System

Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)



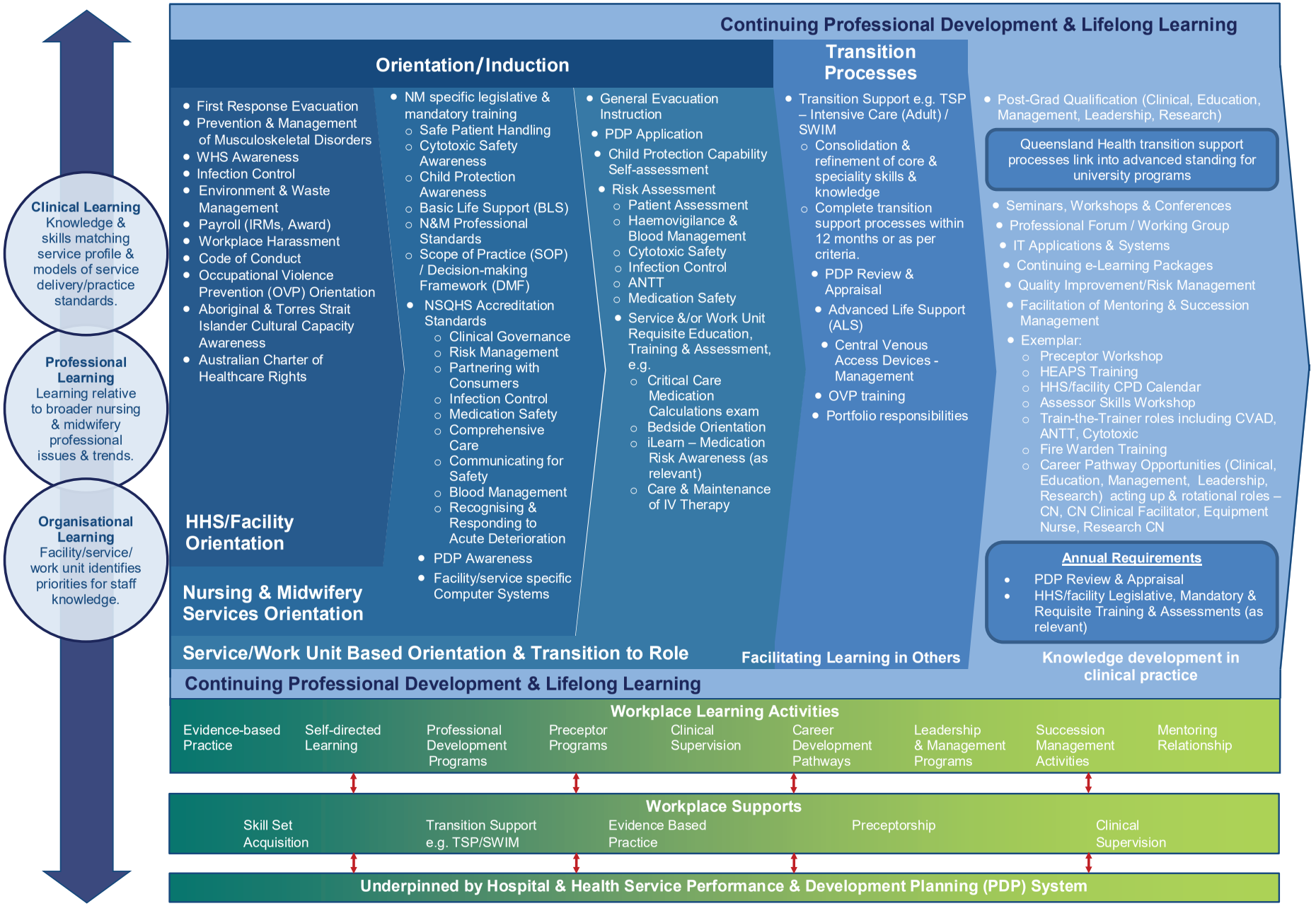
Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)

Critical Care (ICU) RN without post graduate critical care qualifications



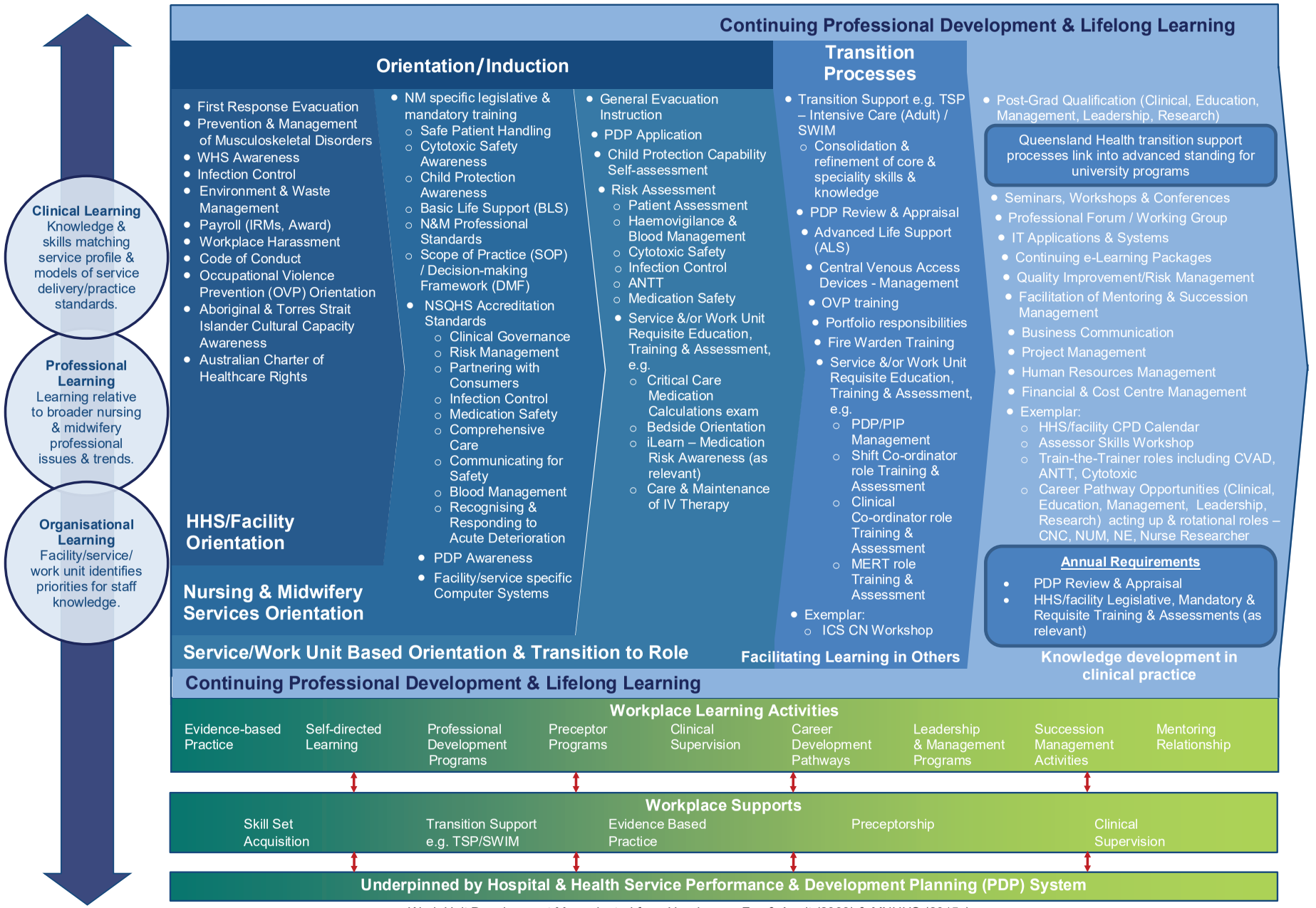
Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)

Critical Care (ICU) RN with post graduate critical care qualifications



Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)

Critical Care Grade 6 Clinical Nurse Band 1



Work Unit Development Map adapted from Henderson, Fox & Armit (2008) & MNHHS (2015c)

Appendix 5: Broad snapshot of a sample Legislative, Mandatory and Requisite Skills Register

Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service (NSQHS) Standards

- *Standard 1* Clinical Governance
- *Standard 2* Partnering with Consumers
- *Standard 3* Preventing and Controlling Healthcare Associated Infection
- *Standard 4* Medication Safety
- *Standard 5* Comprehensive Care
- *Standard 6* Communicating for Safety
- *Standard 7* Blood Management
- *Standard 8* Recognising and Responding to Acute Deterioration

LEGISLATIVE	Training Required by Law
MANDATORY	Training not necessarily required by law but which has been identified by Metro North Hospital and Health Services (MNHHS) as mandatory/compulsory for staff or required by relevant directives.
REQUISITE	Training required for specific groups of staff to enable them to perform their role to meet professional and local service requirements
UPSKILLING	Any training or education that provides a participant with a new or additional knowledge or skills to enhance workforce capacity and capability (Excludes Legislative, Mandatory or Requisite Skills)

Legislative, Mandatory, Requisite and Upskilling Training Categories are determined at a HHS/Facility/Directorate/Service/Work Unit level as endorsed by the relevant governance committee.

Nursing and Midwifery staff are to comply with the requirements outlined in the relevant 'HHS/Facility/Directorate/Service Legislative and Mandatory Training' policy/ procedure. Information regarding legislative, mandatory training and orientation is available on the HHS/Facility/Directorate/Service intranet page.

The Skills Register is intended to supplement the HHS/Facility/Directorate/Service policy/procedure and guide nursing/midwifery managers and staff to determine the range of training requirements for staff classification to meet service delivery needs.

Training is to be entered into the respective HHS/Facility/Directorate/Service training database to enable monitoring and management of training compliance,

All risks must be managed according to the HHS/Facility/Directorate/Service Risk Management Framework. The use of a Risk Analysis Matrix is mandatory when assessing and communicating risks to Executive and Senior Management within the HHS/Facility/Directorate/Service.

LEGISLATIVE: Training Required by Law
Local reporting processes and relevant filing/documentation into individual's Performance and Development Planning (PDP) file.

Skill	Training / Assessment Frequency	ND / AND	NP	NO7 (NUM, NM, CNC, NR, NE)	CN, CF / CT	RN / Midwife	DEM	ENAS	EN	AIN
First Response Evacuation DVD	Induction and Annual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
General Evacuation Instruction	Induction and Annual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Evacuation Coordination Instruction	Induction and Annual	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
Cytotoxic Safety: Category 1	Induction (once only)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cytotoxic Safety: Category 2	Induction (once only) based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
Cytotoxic Safety: Category 3	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
Child Protection Presentation	Induction (once only)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Child Safety - Capability Self-Assessment	Induction and Annual	Yes	Yes	Yes	Yes	Yes	Yes	Risk-Assess	Risk-Assess	Risk-Assess
Work Health and Safety	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

MANDATORY – Training not necessarily required by law but which has been identified by HHS/Facility/Directorate/Service as mandatory/compulsory for staff or required by relevant directives.
Local reporting processes and relevant filing/documentation into individual's Performance and Development Planning (PDP) file.

Skill	Training / Assessment Frequency	ND / AND	NP	NO7 (NUM, NM, CNC, NR, NE)	CN, CF / CT	RN / Midwife	DEM	ENAS	EN	AIN
Code of Conduct (Public Sector) Training - 'Our Queensland Health Way'	Induction (once only)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
• National Code of Conduct for (Unregulated) Health Care Workers (Queensland)		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Yes
• Code of Conduct (Public Sector) Compliance Assessment	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Prevention and Management of Musculoskeletal Disorders e-Learning	Induction (once only)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Patient Handling Techniques	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
Manual/Materials Handling Techniques	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
Computer Workstation / Office Ergonomics	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
General Infection Prevention and Control	Induction and Annual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Aseptic Non- Touch Technique (ANTT)	Induction (once only)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A
Haemovigilance and Blood Management	Biennial	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess

MANDATORY – Training not necessarily required by law but which has been identified by HHS/Facility/Directorate/Service as mandatory/compulsory for staff or required by relevant directives.
Local reporting processes and relevant filing/documentation into individual's Performance and Development Planning (PDP) file.

Skill	Training / Assessment Frequency	ND / AND	NP	NO7 (NUM, NM, CNC, NR, NE)	CN, CF / CT	RN / Midwife	DEM	ENAS	EN	AIN
Patient Assessment	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	N/A	N/A	N/A
Basic Life Support (BLS) with Automated External Defibrillator (AED)	Induction and Annual	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Intermediate Life Support (ILS)	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
Advanced Life Support (ALS)	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	N/A	N/A	N/A
Neonatal Life Support	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	N/A	N/A	N/A	N/A
Occupational Violence Prevention (OVP) – Level 1: Orientation DVD	Induction (once only)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
OVP – Level 2: Awareness	Induction (once only) based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
OVP – Level 3: Verbal De-Escalation	Induction (once only) based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
OVP – Level 3: Verbal De-Escalation	Induction (once only) based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
OVP – Level 4: Basic Personal Safety (BPS)	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
OVP – Level 5: Restrictive Practices	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess

MANDATORY – Training not necessarily required by law but which has been identified by HHS/Facility/Directorate/Service as mandatory/compulsory for staff or required by relevant directives.
Local reporting processes and relevant filing/documentation into individual's Performance and Development Planning (PDP) file.

Skill	Training / Assessment Frequency	ND / AND	NP	NO7 (NUM, NM, CNC, NR, NE)	CN, CF / CT	RN / Midwife	DEM	ENAS	EN	AIN
PDP Completion (all staff except Casuals)	Induction and Annual (casual staff exempt)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
QH, HR and HHS Policies, Facility/ Directorate/ Service Procedures	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Safe Medication Assessment	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Falls Prevention	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pressure Injury Prevention	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Risk Management	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Australian Charter of Healthcare Rights	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Open Disclosure	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Communication and Customer Service	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Aboriginal and Torres Strait Islander Cultural Practice Program	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Waste Management	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hazardous Materials	Annual Peer Review within PDP	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

REQUISITE - Training required for specific groups of staff to enable them to perform their role to meet professional and local service requirements. *Local reporting processes and relevant filing/documentation into individual's Performance and Development Planning (PDP) file.*										
Skill	**Training / Assessment Frequency**	**ND / AND**	**NP**	**NO7 (NUM, NM, CNC, NR, NE)**	**CN, CF / CT**	**RN / Midwife**	**DEM**	**ENAS**	**EN**	**AIN**
Examples										
Care and Maintenance of IV Therapy	Annual Appraisal based on Risk Assessment	Risk-Assess	Yes	Risk-Assess	Yes	Yes	Yes	Yes	Yes	N/A
Peripheral Intravenous Cannulation (PIVC)	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	N/A	N/A	N/A
Venepuncture	Annual Appraisal based on Risk Assessment	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	N/A	N/A	N/A
PDP for Team Leaders	Annual Peer Review within PDP	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	N/A	N/A	N/A
Preceptor Program	Annual Peer Review within PDP	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess
Shift Coordination	Annual Peer Review within PDP	N/A	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	Risk-Assess	N/A	N/A	N/A

References

Ackerman, M. H., Norsen, L., Martin, B., Wiedrich, J., & Kitzman, H. J. (1996). Development of a model of advanced practice. *American Journal of Critical Care*, 5: 68-73.

Aitkin, R.L., Faulkner, R., Bucknall, T. & Parker, J. (2002). *Aspects of Nursing and Midwifery Education: The Types of Skills and Knowledge required to meet the changing needs of the labour force involved in nursing – Literature review.* Commissioned Research Project for the Commonwealth Department of Education, Science and Training.

Alden, K. & Durham, C. (2012). Integrating reflection in simulation: structure, content, and process. In G. Sherwood, & S. Horton-Deutsch (Ed.), *Reflective Practice: Transforming Education and Improving Outcomes* (pp. 149-168).Indianapolis, US: Sigma Theta Tau International.

Aon Hewitt. (2012). *Best-in-Class Succession Management: Who Will Take the Baton?* Lincolnshire, Illinois: Top Companies for Leaders Research.

Arnold, J. (2016). *Coaching Skills for Leaders in the Workplace: How to unlock potential and maximise performance.* London, UK: Little Brown Book Group.

Association of Public Health Nursing Management (ANDSOOHA). (n.d.) *Caring, Connecting, Empowering: A Resource Guide for Implementing Nursing Mentorship in Public Health Units in Ontario.* Ontario, Canada: Ontario Ministry of Health & Long-Term Care.

Association of Queensland Nursing and Midwifery Leaders (AQNML). (2013). *AQNML Mentoring Framework and Toolkit.* Brisbane, QLD: AQNML.

Australian Clinical Supervision Association (ACSA). (2015). Definitions of Clinical Supervision. Brisbane, QLD: ACSA.

Australian College of Operating Room Nurses (ACORN). (2016). *ACORN Standards for Perioperative Nursing in Australia* (14th ed.). Lyndoch, South Australia: ACORN.

Australian College of Critical Care Nurses. (ACCCN). (2015). *ACCCN Practice Standards for Critical Care Nurses* (3rd ed.).

Australian College of Mental Health Nurses (ACMHN). (2010). *Standards of Practice in Mental Health Nursing.* Deakin West, ACT: ACMHN.

Australian Council on Healthcare Standards (ACHS). (2012). *EQuIPNational Guidelines: Standard 13 Workforce Planning and Management.* Sydney: NSW: ACHS.

Australian Council on Healthcare Standards (ACHS). (2017). *National Safety and Quality Health Service (NSQHS) Standards* (2nd ed.). Sydney: NSW: ACHS.

Australian Government. (2010). *National Standards for Mental Health Services.* Canberra: Commonwealth of Australia.

Australian Human Resources Institute. (2018a). Learning and Development.

Australian Human Resources Institute. (2018b). *Organisational Development.*

Australian Nursing and Midwifery Federation (ANMF). (2014). *ANMF Professional Paper – Is it advanced or expanded practice?*

Australian Nursing and Midwifery Federation (ANMF). (2016). *ANMF Position Statement – Re-entry to the nursing and midwifery workforce.*

Australian Public Service (APS). (2012). Australian Public Service (APS) Workforce Planning Guide, Canberra: Australian Government.

Australian Qualification Framework Council. (2013). *Australian Qualifications Council* (2nd ed.).

Bandura, R.P. & Lyons, P. (2017). Coaching to enhance self-regulated learning. *Human Resource Management International Digest,* 25(4): 3-6.

Baraz, S. Memarian, R. & Vanaki, Z. (2015). Learning challenges of nursing students in clinical environments: A qualitative study in Iran. *Journal of Education and Health Promotion*, 4: 52.

Bengtsson, M. & Carlson, E. (2015). Knowledge and skills needed to improve as preceptor: Development of a continuous professional development course – A qualitative study Part 1. *BMC Nursing*, 14(51): 1-7.

Bersin by Deloitte. (2014). Bersin by Deloitte Research: *Effective Succession Management Tied to Strong Employee Engagement and Retention.* New York, NY: Deloitte Consulting LLP.

Besner, J., Doran, S., McGillis Hall, L., Giovanetti, P., Girard, F., Hill, W., Morrison,J. & Watson, L. (2005). *A Systematic Approach to Maximizing Nursing Scopes of Practice*. Ottawa: Canadian Institute of Health Research.

Bifarin, O. & Stonehouse, D. (2017). Clinical Supervision: an important part of every nurse's practice. *British Journal of Nursing, 26*(6): 331-335.

Billett, S. (2001). *Learning in the workplace; Strategies for effective practice*. Australia: Allen and Unwin.

Billett, S. (2004). Workplace participatory practices: Conceptualising workplaces as learning environments. *Journal of Workplace Learning,* 16(6), 312-324. doi: 10.1108/13665620410550295

Billett, S. (2016). Learning through health care work: premises, contributions and practices. *Medical Education,* 50(1): 124-131. doi: 10.1111/medu.12848.

Bolman, L.G. & Deal, T.E. (2017). Reframing organizations: artistry, choice, and leadership (6th ed.). Hoboken, NJ: Jossey-Bass.

Bond University. (2018). *Academic Coaching Workshops: Coaching @ Bond.* Robina, QLD: Bond University.

Booker, C. (2011). *An exploration of factors that influence end of career nurses' decision making regarding their workforce participation.* Submitted in fulfilment of the requirement of the degree of Doctor of Philosophy School of Educational Leadership, Faculty of Education Australian Catholic University Brisbane, Australia.

Booker, C., Turbutt, A. & Fox, R. (2016). Model of care for a changing healthcare system: are there foundational pillars for design? *Australian Health Review*, 40(2), 136–140. doi: 10.1071/AH14173.

Bowen, A., Fox, R. & Burridge, C. (2012). Preceptorship – Making A Difference. *Journal of Nurses' Staff Development, 28*(2), E12 – 5.

Brewer, A.M. (2016). *Mentoring from a Positive Psychology Perspective.* Geneva, Switzerland: Springer International Publishing. doi: 10.1007/978-3-319-40983-2_2

Bridges, R.P., Herrin, D., Swart, T., McConnell, M.T. & Toma, M. (2014). Creating an Innovative Educational Structure to Support Best Practice Among Novice Nurses. *The Journal of Continuing Education in Nursing, 45*(2), 60-64.

Calo, T.J. (2008). Talent Management in the Era of the Aging Workforce: The Critical Role of Knowledge Transfer, *Public Personnel Management, 37*(4), 403-416.

Carlson, E., Pilhammar, E. & Wann-Hansson, C. (2010). Time to precept: Supportive and limiting conditions for precepting nurses. *Journal of Advanced Nursing, 66*: 432-441.

Carrick, L., Clarke, S. & Thompson, J. (2008). Solving the Leadership Dilemma: Where will nursing's next leaders come from? *The Pennsylvania Nurse, 63*(1): 12-13.

Cacciattolo, K. (2015). Defining Workplace Learning. *European Scientific Journal, 1*(May): 243-250.

Centres for Disease Control and Prevention. (2013). *A Guide to Help Ensure Use of Evaluation Findings.* Atlanta, GA: US Department of Health and Human Services.

Chichester, M. (2011). Lifelong Learning, Part 2 – Pursuing your BSN and Beyond. *Nursing for Women's Health, 15*(2): 171-175.

Cleary, M., Horsfall, J., O'Hara-Aarons, M., Jackson, D. & Hunt, G.E. (2011). The views of mental health nurses on continuing professional development. *Journal of Clinical Nursing, 20*: 3561-3566.

Cochran-Smith, M., & Lytle, S. (2001). Beyond certainty: Taking an inquiry stance on practice. In: A. Lieberman & L. Miller (Eds.), *Teachers caught in the action: Professional development that matters.* New York: Teachers College Press.

Cole, P. (2012). *Linking effective professional learning with effective teaching practice.* Melbourne, VIC: Australian Institute for Teaching and School Leadership.

College of Registered Nurses of Nova Scotia (CRNNS). (2015). *Interpreting and modifying the Scope of Practice of the Registered Nurse.* Halifax, Canada: CRNNS.

Collins, J. (2009). Education Techniques for Lifelong Learning: Lifelong Learning in the 21st Century and Beyond. *RadioGraphics, 29*: 613-622. doi: 10.1148/rg.292085179

Collins. (2018). 'lifelong learning'. *Collins English Dictionary*. Sydney, NSW: HarperCollins Publishers.

Conway, J. & McMillan, M. (2015). Professional career development: development of the capable nursing professional. In Chang, E & Daly, J. (Ed.), *Transitions in Nursing: Preparing for Professional Practice* (pp. 309-328). Chatswood, NSW: Elsevier Publishers.

Courtney-Pratt, H., FitzGerald, M., Ford, K., Marsden, K. & Marlow, A. (2012). Quality clinical placements for pre-registration nursing students: a cross-sectional survey of undergraduates and supervising nurses. *Journal of Advanced Nursing, 68*(6): 1380–1390.

CPS HR Consulting. (2017). *Succession planning: Preparing for your agency's future.* Sacramento, CA: CPS HR Consulting.

Daley, B. (2001). Learning and professional practice: A study of four professions. *Adult Education Quarterly, 52*(1): 39-54. doi:10.1177/074171360105200104

Daly, W.M. & Carnwell, R. (2003). Nursing roles and levels of practice: A framework for differentiating between elementary, specialist and advancing nursing practice. *Journal of Clinical Nursing, 12*: 158-167.

Davis, K. (2015). *The influence of workplace culture on nurses' learning experiences: a systematic review of the qualitative evidence.* Submitted in fulfilment of the requirement of the degree of Master of Clinical Science (Evidence Based Healthcare) School of Translational Health Science, Faculty of Health Sciences, The University of Adelaide, Australia.

Dean, H.D., Myles, R.L., Spears-Jones, C., Bishop-Cline, A. & Fenton, K.A. (2014). A Strategic Approach to Public Health Workforce Development and Capacity Building. *American Journal of Preventive Medicine, 47*(5): S288-S296.

Deloitte. (2016). Succession management—Developing the next generation of Federal leaders. New York, NY: Deloitte Development LLC.

Department of Education, Training & Employment (DETE). (2014). Standards for professional development. Brisbane, QLD: Education Queensland, Queensland Government.

Department of Health. (2013). *Review of Australian Government Health Workforce Programs.* Canberra, ACT: Commonwealth of Australia.

Department of Health & Human Services (DHHS). (2014). *Transition to Practice Framework for Nurses and Midwives.* Hobart, Tasmania: Tasmanian Government.

Duff, B., Gardner, G. & Osborne, S. (2012). An integrated educational model for continuing nurse education. *Nurse Education Today,* 34(2014): 104-111.

Dweck, C.S., Walton, G.M. & Cohen, G.L. (2014). *Academic Tenacity: Mindsets and skills that promote long-term learning.* Seattle, Washington: Bill & Melinda Gates Foundation.

Earle, V, Myrick, F. & Yonge, O. (2010). Preceptorship in the intergenerational context: an integrative review of the literature. *Nurse Education Today. 31*(2011): 82-87.

Edwards, J.S. (Ed.). (2015). *The Essentials of Knowledge Management.* London, UK: Palgrave Macmillan.

Edwards, S. (2017). Reflecting differently. New dimensions: reflection-before-action and reflection-beyond-action. *International Practice Development Journal, 7*(1): 1-14.

Ehrich, L. (2013). *Developing Performance Mentoring Handbook.* Brisbane, QLD: Department of Education, Training and Employment.

El Haddad, M. (2016). *Grounded theory examination of the perspective of practice and education sectors regarding graduate registered nurse practice readiness in the Australian context.* Submitted in fulfilment of the requirement of the degree of Doctor of Philosophy thesis, School of Nursing, University of Wollongong.

Elmore, R. E. (2000). Building a New Structure for School Leadership. Albert Shanker Institute.

Eraut, M. (2000). Non-formal learning and tacit knowledge in professional work. *British Journal of Educational Psychology, 70*(1): 113-136.

Fahey, C., & Monaghan, J. (2005). Australian rural midwives' perspectives on continuing professional development. *The International Electronic Journal of Rural and Remote Health, Research, Education, Practice and Policy.*

Federation University. (2014). *LT1432 Learning Pathways Policy.* Ballarat, NSW: Federation University Australia.

Ferraro, J.M. (2000). *Reflective Practice and Professional Development.*

Fischer, G. (2014) Supporting Self-Directed Learning with Cultures of Participation in Collaborative Learning Environments. In E. Christiansen, L. Kuure, A. Mørch, & B. Lindström (Ed.), *Problem-Based Learning for the 21st Century - New Practices and Learning Environments* (pp. 15-50). Aalborg, Denmark: Aalborg University Press.

Flinders University. (n.d.). *What is Induction and Orientation and Why is it Needed?*

Fox, R. (2013). *The role and contribution of the Queensland public sector employed nurse educator: A grounded theory study.* Submitted in fulfilment of the requirement of the degree of Doctor of Philosophy School of Nursing and Midwifery, Faculty of Health Sciences Institute of Health and Biomedical Innovation Queensland University Of Technology Brisbane, Australia.

Fox, R; Henderson, A. & Malko-Nyhan, K. (2005). They survive despite the organisational culture not because of it – A longitudinal study of new staff perceptions of what constitute support during transition to an acute tertiary facility. *International Journal of Nursing Practice. 11*: 193-199.

Ganser, T. (2000). An ambitious vision of professional development for teachers. In NASSP. *Bulletin, 84*(618), 6-12. doi: 10.1177/019263650008461802

Gardner, G., Chang, A., Duffield, C. (2007). Making nursing work: breaking through the role confusion of advanced practice nursing. *Journal of Advanced Nursing, 57*(4): 382–391, doi.org/10.1111/j.1365-2648.2006.04114.x.

Gardner, G., Duffield, C., Doubrovsky, A. & Adams, M. (2016). Identifying Advanced Practice: A national survey of a nursing workforce. *International Journal of Nursing Studies, 55*(2016): 60-70.

Garvin, D., Edmondson, A. & Gino, F. (2008). Is yours a learning organization? *Harvard Business Review,* March: 109-116.

Gifford, J. & Yarlagadda, R. (2018). Employee engagement and motivation. Wimbledon, UK: Chartered Institute of Personnel & Development (CIPD).

Glen, S. (2000). Critique of the graduate nurse: An international perspective. *Nurse Education Today, 20*: 20–25.

Gopee, N. (2008). *Mentoring and Supervision in Healthcare*. London, UK: Sage Publications.

Gravells, A. (2016). *Principles and Practices of Quality Assurance: A guide for internal and external quality assurers in the FE and Skills Sector.* London, UK: SAGE Publications Ltd.

Gray, A. (2016). Advanced or advancing nursing practice: What is the future direction for nursing? *British Journal of Nursing, 25*(1): 8-13.

Grindel, C.G. (2004). Mentorship: a key to retention and recruitment. *Medsurg Nursing: Official Journal Of The Academy Of Medical-Surgical Nurses,* 13(1): 36-37.

Groves, K.S. (2007). Integrating leadership development and succession planning best practices, *Journal of Management Development, 26*(3): 239-260.

Grundy, C. (2017). *The Importance of Succession Planning*. London, UK: Association of Professional Staffing Companies (APSCo).

Haggerty, C, Holloway, K. & Wilson, D. (2013). How to grow our own: an evaluation of preceptorship in New Zealand graduate nurse programmes. *Contemporary Nurse. 43*(2): 162-171.

Hall, D.T. & Moss, J.E. (1998). The New Protean Career Contract: Helping organizations and employees adapt, *Organizational Dynamics, 26*: 22-37.

Hayes, H., Scott, V., Abraczinskas, M., Scaccia, J., Stout, S. & Wandersman, A. (2016). A formative multi-method approach to evaluating training. *Evaluation and Program Planning, 58*: 199-207.

Health and Care Professionals Council (HCPC). (2017). *Continuing professional development and your registration*. London, UK: HCPC.

Health System Performance Assessment (HSPA). (2017). *Reporting and communicating: Practical guide for policy makers*. Brussels, Belgium: European Commission – Health and food Safety.

Heartfield, M., Gibson, T., Chesterman, C. & Tagg, L. (2005). *Hanging from a String in the Wind: Mentoring for Nurses in General Practice: Final Report.* Department of Health & Ageing: Commonwealth Government.

Henderson A., Fox, R. and Malko-Nyhan, K. (2006). An Evaluation of Preceptors' Perceptions of Educational Preparation and Organizational Support for Their Role. *The Journal of Continuing Education in Nursing, 37*(3): 130-136.

Henderson, A., Fox, R. & Armit, L. 2008. Education in the clinical context: Establishing a strategic QHNMSDF to ensure relevance. *Collegian, 15*: 63-68.

Higginbottom, K. (2014). Effective succession management results in improved employee engagement. *Forbes, Nov 20, 2014*.

Hilli, Y., Melender, H.L., Salmu, M. & Jonsén, E. (2014). Being a preceptor – A Nordic qualitative study. *Nurse Education Today, 34*: 1420-1424.

Hughes, A.J. & Fraser, D.M. (2011). 'SINK or SWIM': The experience of newly qualified midwives in England. *Midwifery, 27*: 382-386.

Huybrecht, S., Loeckx, W., Quaeyhaegens, Y. De Tobel, D. & Mistiaen, W. (2011). Mentoring in nursing education: Perceived characteristics of mentors and the consequences of mentorship. *Nurse Education Today, 31*(3), 274-278. doi:10.1016/j.nedt.2010.10.022.

Innovation & Growth. (2012). *A Guide to Succession Management,* Nova Scotia Public Service Commission.

International Confederation of Midwives (ICM). (2013). *Essential Competencies for Basic Midwifery Practice*. The Hague, Netherlands: ICM.

International Confederation of Midwives (ICM). (2014). *International Code of Ethics for Midwives*. The Hague, Netherlands: ICM.

International Council of Nurses (ICN). (2012). *ICN Code of Ethics for Nurses*. Geneva, Switzerland: ICN.

Interprofessional Ambulatory Care (IpAC) Unit. (n.d.). Reflective practice: a tool to enhance professional practice. Perth, WA: Edith Cowan University.

James, A. & Chapman, Y. (2010). Preceptors and patients - the power of two: nursing student experiences on their first acute clinical placement. *Contemporary Nurse, 341*: 34-47.

Jayatilleke, N. & Mackie, A. (2012). Reflection as part of continuous professional development for public health professionals: a literature review. *Journal of Public Health, 35*(2): 308–312.

Jenkins, D. & Spence, C. (2006). *The Career Pathways How-to-Guide*. Brooklyn, NY: Workforce Strategy Center.

Jones, J. (2006). Clinical Supervision in Nursing. *The Clinical Supervisor, 24*(1-2): 149-162.

Jones, R. (2015). *The effectiveness of workplace coaching: A meta-analysis of learning and performance outcomes; scale development; theoretical model of individual differences and longitudinal study.* Submitted in fulfilment of the requirement of the degree of Doctor of Philosophy, Business School - Aston University: Birmingham, England.

Kalinski, B.S. (Eds.). (2014). Professional Education. Encyclopedia of Business and Finance (3rd Ed.). New York City, New York: Macmillan Reference USA.

Kalischuk, R.G., Vandenberg, H. & Awosoga, O. (2013). Nursing preceptors speak out: An empirical study. *Journal of Professional Nursing, 29*: 30-38.

Kallenbach, J.Z. (2016). On being a Preceptor. In J.Z. Kallenbach (ed.), *Review of Hemodialysis for Nurses and Dialysis Personnel* (pp. 332-337). St Louis, Missouri: Elsevier.

Katsikitis, M., Mcallister, M., Sharman, R., Raith, L., Faithfull-Byrne, A. & Priaulx, R. (2013). Continuing professional development in nursing in Australia: Current awareness, practice and future directions. *Contemporary Nurse, 45*(1): 33-45. doi: 10.5172/conu.2013.45.1.33.

Ke, Y.T., Kuo, C.C. & Hung, C.H. (2017). The effects of nursing preceptorship on new nurses' competence, professional socialization, job satisfaction and retention: A systematic review. *Journal of Advanced Nursing (JAN)*, 73: 2296–2305.

Kelly, J. & McAllister, M. (2013). Lessons students and new graduates could teach: A phenomenological study that reveals insights on the essence of building a supportive learning culture through preceptorship. *Contemporary Nurse, 44*:170-177.

King, W.R. (Ed.). (2009). *Knowledge Management and Organisational Learning.* London, UK: Springer Science.

Kinsella, E. (2010). Professional knowledge and the epistemology of reflective practice. *Nursing Philosophy, 11*(1), 3-14.

Kippers, W.B., Poortman, C.L., Schildkamp, K. & Visscher, A.J. (2018). Data literacy: What do educators learn and struggle with during a data use intervention? *Studies in Educational Evaluation, 56*: 21-31.

Kirkpatrick, J.D. & Kayser Kirkpatrick, W. (2016). *Kirkpatrick's Four Levels of Training Evaluation*. Alexandria, VA: ATD Press.

Kitto, S., Goldman, J., Schmitt, M.H. & Olson, C.A. (2014). Examining the intersections between continuing education, interprofessional education and workplace learning. *Interprofessional Care,* Early Online: 1-3.

Laal, M. (2011). Lifelong learning: What does it mean? *Procedia - Social and Behavioral Sciences 28*(2011): 470–474. doi: 10.1016/j.sbspro.2011.11.090.

Lamoureux, K. (2009). Succession Management. *Leadership Excellence, 26*(6): 18.

Leeds Metropolitan University. (2009). *Writing and using good learning outcomes*. Leeds, UK: Leeds Metropolitan University.

Leners, D.W., Wilson, V. W., Connor, C. & Fenton, J. (2006). Mentorship: increasing retention probabilities. *Journal of Nursing Management, 14*(8): 652-654.

Liverpool John Moores University (LJMU). (2015). *Personal Development Planning Policy.* Liverpool, UK.

Longe, J. & Narins, B. (Eds.). (2017). The Gale Encyclopedia of Nursing and Allied Health (4th Ed.). Farmington Hills, Michigan: Cengage Gale Learning.

Lynch, K., Akridge, J.T., Schaffer, S.P. & Gray, A. (2006). A framework for evaluating return on investment in management development programs. *International Food and Agribusiness Management Review, 9*(2), 54-70.

Lyth, G. (2000). Clinical Supervision: a concept analysis. *Journal of Advanced Nursing, 31*(3): 722-729

MacNaughton, G. (2003). Reflecting on early childhood curriculum. In G. MacNaughton, *Shaping Early Childhood* (pp. 113-120). England: Open University Press.

Mann, K., Gordon, J. & MacLeod, A. (2009). Reflection and reflective practice in health professions education: a systematic review. *Advances in health sciences education, 14*(4): 595–621.

Mark, B.A., Salyer, J. & Wan, T.T.H. (2003). Professional Nursing Practice: Impact on Organizational and Patient Outcomes. *Journal of Nursing Administration, 33*(4): 224–234.

Martin-Misener, R. & Bryant-Lukosius, D. (2014). *Optimising the Role of Nurses in Primary Care in Canada.* Ottawa, Ontario: Canadian Nurses Association (CNA).

Massey University. (2017). *Performance and Development Planning website.* Auckland, New Zealand.

Mathews, P. (1999). Workplace learning: Developing an holistic model. *Learning Organisation Journal, 6*(1), 18-29. doi: 10.1108/09696479910255684.

Matthews, J.H. (2012). Role of Professional Organizations in Advocating for the Nursing Profession. *OJIN: The Online Journal of Issues in Nursing, 17*(1).

Matua, G.A., Seshan, V., Savithri R. & Fronda, D.C. (2014). Challenges and strategies for building and maintaining effective preceptor-preceptee relationships among nurses. *Sultan Qaboos University Medical Journal, 14*(4): e530-536.

Maxwell, B. (2014). Improving workplace learning of lifelong learning sector trainee teachers in the UK. *Journal of Further and Higher Education, 38*(3): 377-399. Doi: 10.1080/0309877X.2013.831036

McCusker, C. (2013). Preceptorship: professional development and support for newly registered practitioners. *Open Learning Zone. 23*(12): 283-287.

McIlveen, P. (2009). Career development, management, and planning from the vocational psychology perspective. *In: Collin, Audrey and Patton, Wendy, (eds.) Vocational psychological and organisational perspectives on career: toward a multidisciplinary dialogue.* Career Development Series (3). Sense Publishers, Rotterdam, Netherlands, pp. 63-90.

McLaughlin, M., & Zarrow, J. (2001). A teacher engages in evidence – based reform: Trajectories of teachers' inquiry, analysis and action. In A. Lieberman & L. Miller (Eds.), *Teachers caught in the action: Professional development that matters.* New York: Teachers College Press.

McMahon, M., Patton, W. & Tatham, P. (2002). *Managing lifelong learning and work in the 21st century,* DETYA: Canberra.

Medd, W. (2011). Coaching for research in UK higher education institutions: a review, Vitae. Cambridge: Vitae.

Mehdaova, E.A. (2017). *Strategies to Overcome the Nursing Shortage.* Submitted in fulfilment of the requirement of the degree of Doctor of Business Administration - Walden University: Minneapolis, MN.

Mental Health Coordinating Council (MHCC). (2008). Mental Health Recovery - *Philosophy into Practice: A workforce development guide (Workforce Development Pathway 8 – Supervision, Mentoring & Coaching)*. Rozelle, NSW: Mental Health Coordinating Council.

Metro North Hospital and Health Service (MNHHS). (2014a). *Mandatory and Legislative Training for all staff policy.* Brisbane, QLD: MNHHS.

Metro North Hospital and Health Service (MNHHS). (2014b). *MNHHS Performance and Development Planning (PDP) Information Manual for Nurses, Midwives and Assistants in Nursing.* Brisbane, QLD: MNHHS.

Metro North Hospital and Health Service (MNHHS). (2014c). *Metro North Hospital and Health Service Education and Workforce Development Outcomes Report.* Metro North Hospital and Health Service: Brisbane.

Metro North Hospital and Health Service (MNHHS). (2015a). *MNHHS Succession Management and Mentoring Framework for Nurses and Midwives.* Brisbane, QLD: MNHHS.

Metro North Hospital and Health Service (MNHHS). (2015b). *MNHHS Succession Management and Mentoring Toolkit for Nurses and Midwives.* Brisbane, QLD: MNHHS.

Metro North Hospital and Health Service (MNHHS). (2015c). *MNHHS Framework for Lifelong Learning for nurses and midwives working within Metro North Hospital and Health Service (MNHHS).* Brisbane, QLD: MNHHS.

Metro North Hospital and Health Service (MNHHS). (2016). *Recognition of Prior Learning (RPL) and Recognition of Current Competency (RCC) Application Guide.* Brisbane, QLD: MNHHS.

Metro North Hospital and Health Service (MNHHS). (2017a). *MNHHS Nursing and Midwifery Education and Workforce Development Action Plan 2017 – 2020.* Metro North Hospital and Health Service: Brisbane.

Metro North Hospital and Health Service (MNHHS). (2017b). *Choosing your Nursing and Midwifery Career Pathway website.* Metro North Hospital and Health Service: Brisbane.

Metro North Hospital and Health Service (MNHHS). (2017c). *Nursing and Midwifery Career Pathways Factsheet.* Metro North Hospital and Health Service: Brisbane.

Ministerial Council for Education, Early Childhood Development & Youth Affairs (MCEECDYA). (2014). *Australian Blueprint for Career Development.* Canberra, ACT: Commonwealth of Australia.

Ministerial Taskforce on Clinical Education & Training Steering Committee. (2007). *Ministerial Taskforce on Clinical Education and Training Final Report.* Brisbane, QLD: Queensland Government.

Moore, J. (2017, August 4). The Critical Importance of Succession Planning. *HR Daily Advisor.*

Morgan, A., Cullinane, J. & Pye, M. (2008). Continuing professional development: Rhetoric and practice in the NHS. *Journal of Education and Work, 21*(3), 233-248. doi: 10.1080/13639080802214100

Morgan, G. (2009). Reflective practice and self-awareness. *Perspectives in Public Health, 129*(4):161-2.

Morley, M. (2013). Preceptorship Handbook for Occupational Therapists (3rd ed.). London, UK: College of Occupational Therapists Ltd.

Morton-Cooper, A. & Palmer, A. (2000). Mentoring, *Preceptorship and Clinical Supervision. A Guide to Professional Support Roles in Clinical Practice* (2nd Edn). London, UK: Blackwell Science Ltd.

Muir, J., Ooms, A., Tapping, J., Marks-Maran, D., Phillips, S. & Burke, L. (2013). Preceptors' perceptions of a preceptorship programme for newly qualified nurses. *Nurse Education Today, 33*(6): 633-638.

Mulford, B. & Silins, H. (2010). Organisational Learning in Schools. In P. Peterson, E. Baker & B. McGaw (Ed.), *International Encyclopedia of Education* (3rd ed.) (pp. 143-150). Oxford, UK: Elsevier.

Murphy, G., & Calway, B. (2008). Professional development for professionals beyond learning. *Australian Journal of Adult Learning, 48* (3), 424-444.

Myrick, F. & Yonge, O. (2005). *Nursing Preceptorship. Connecting Practice & Education.* Philadelphia: Lippincott Williams & Wilkins.

National Health Work Taskforce (NHWT). (2009). Health workforce in Australia and factors for current shortages.

National Scientific Council on the Developing Child. (2015). *Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper 13*. Cambridge, MA: Harvard University.

Nelson, S., Turnbull, J., Bainbridge, L., Caulfield, T., Hudon, G., Kendel, D., Mowat, D., Nasmith, L., Postl, B., Shamian, J., Sketris I. (2014). *Optimizing Scopes of Practice: New Models for a New Health Care System.* Ottawa, Ontario: Canadian Academy of Health Sciences.

Ng, L.C., Tuckett, A.G., Fox-Young, S.K. & Kain, V.J. (2014). Exploring registered nurses' attitudes towards postgraduate education in Australia: an overview of the literature. *Journal of Nursing Education and Practice, 4*(2): 162-170. doi: 10.5430/jnep.v4n2p162.

Ng, L.C.H. (2016). *Exploring registered nurses' attitudes to postgraduate education for specialty practice in Australia.* Submitted in fulfilment of the requirement of the degree of Doctor of Philosophy, School of Nursing, Midwifery and Social Work - University of Queensland: Brisbane, Queensland.

Nielsen, K., Finderup, J., Brahe, L., Elgaard, R., Elsborg, A.M., Engell-Soerensen, V., Holm, L., Juul, H. & Sommer, I. (2017). The art of preceptorship. A qualitative study. *Nurse Education in Practice,* 26: 39-45.

Noland, L. (2018). *The Largest Business Benefits of Having Motivated Employees.* Innovation Enterprise Ltd.

Nova Scotia Public Service Commission. (2015). *Mentoring Program Guide,* Halifax: Province of Nova Scotia.

Nurses and Midwives (Queensland Health and Department of Education and Training) Certified Agreement (EB9) (2016). Brisbane, QLD: Queensland Industrial Relations Commission (QIRC).

Nurses and Midwives (Queensland Health) Award – State 2015 (2017 State Wage Case Reprint). Brisbane, QLD: Queensland Industrial Relations Commission (QIRC).

Nursing and Midwifery Board of Australia (NMBA). (2006). *National competency standards for the midwife.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2007). *A national framework for the development of decision-making tools for nursing and midwifery practice.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2014). *Nurse practitioner standards for practice.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2015). *Assessment of nursing and midwifery applicants for re-entry to practice.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2016a). *Continuing Professional Development Registration Standard.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2016b). Guidelines: *Continuing Professional Development.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2016c). *Enrolled nurse standards for practice.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2016d). *Registered nurse standards for practice.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2016e). *Fact sheet: Advanced nursing practice and specialty areas within nursing.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2017). *Registration Standards website.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2018a). *Code of conduct for midwives.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2018b). *Code of conduct for nurses.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2018c). *Code of conduct for nurses and Code of Conduct for Midwives Fact Sheet.* Melbourne, VIC: NMBA.

Nursing and Midwifery Board of Australia (NMBA). (2018d). *Midwife standards for practice.* Melbourne, VIC: NMBA.

O'Connor, B. (2004). The workplace learning cycle: A problem-based curriculum model for the preparation of workplace learning professionals. *Journal of Workplace Learning, 16*(6), 341-349. doi: 10.1108/1113665620410550312

Office of the Chief Economist. (2015). Choosing appropriate designs and methods for impact evaluation. Canberra, ACT: Department of Industry, Innovation and Science – Australian Government.

Office of the Chief Nursing and Midwifery Officer (OCNMO). (2013a). *Strengthening health services through optimising nursing: Strategy and action plan (2013–2016)*. Brisbane: Queensland Government.

Office of the Chief Nursing and Midwifery Officer (OCNMO). (2013b). *Registered Nurse Professional Practice in Queensland: Guidance for practitioners, employers and consumers*. Brisbane: Queensland Government.

Office of the Chief Nursing and Midwifery Officer (OCNMO). (2014). *Mandating Qualifications for Specialised or Advanced Practice Registered Nurses*. Brisbane: Queensland Government.

Office of the Chief Nursing and Midwifery Officer (OCNMO). (2016). *Business Planning Framework: a tool for nursing and midwifery workload management* (5th ed.). Brisbane: Queensland Government.

Ogbu, J.O. & Osanaiye, J.I. (2017). Impact of Employee Training on Organizational Performance: A Study of Selected Insurance Firms in Abuja-Nigeria. *European Journal of Business and Management, 9*(14): 64-72.

Paradise, A. & Patel, L. (2009). *The ASTD 2009 state of the industry report*. Alexandria, VA: American Society for Training and Development.

Paull, M., Whitsed, C. & Girardi, A. (2016). Applying the Kirkpatrick model: Evaluating Interaction for Learning Framework curriculum interventions. In *Purveyors of fine learning since 1992. Proceedings of the 25th Annual Teaching Learning Forum*, 28-29 January 2016. Perth: Curtin University.

Pennell, K. (2010). The role of flexible job descriptions in succession management, *Library Management, 31*(4/5): 279-290.

Phillips, C., Kenny, A., Esterman, A. & Smith, C. (2014). Does the choice of pre-registration paid employment impact on graduate nurse transition: An Australian Study. *Nurse Education Today. 34*(2014): 532-537.

Pockett, R., Napier L. & Giles, R. (2013). *Critical Reflection for Practice*. In A. O'Hara & R. Pockett (Ed.), Skills for Human Service Practice (2nd ed.). (pp. 9). South Melbourne, Australia: Oxford.

Pool, I., Poell, R., & Cate, O.T. (2012). Nurses' and managers' perceptions of continuing professional development for older and younger nurses: A focus group study. *International Journal of Nursing Studies*, 50, 34-43.

Pritchard, J. & Becker, K. (2009). Succession management as a knowledge management strategy. *In: Enhancing the innovation environment: Proceedings of the 10th International CINet Conference*, 6-8 September 2009, Brisbane, Australia.

Queensland Government. (2008). *Evaluation of Learning and Development Activities Guideline. How do we know the program really works?* Brisbane, QLD: Queensland Government.

Queensland Government. (2011). *Code of Conduct for the Queensland Public Service*. Brisbane, QLD: Queensland Government.

Queensland Health. (2004). *Queensland Health Mentoring Framework for Nurses*. Brisbane, QLD: Queensland Government.

Queensland Health. (2009). *Clinical Supervision Guidelines for Mental Health Services*. Brisbane, QLD: Queensland Government.

Queensland Health. (2010). *Queensland Health Preceptor Program*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2011). *Building Blocks of Lifelong Learning: A Framework for nurses and Midwives in Queensland*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2012). *Transition Support Programs User Guide* (Adapted for MNHHS context). Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2013a). *Strengthening health services through optimising nursing – strategy and action plan (2013-2016)*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2014a). *Department of Health Strategic Plan 2014-2018 (2015 update)*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2015). *Workforce Diversity and Inclusion Strategy 2017-2022*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2016a). *Health Service Plans and Strategies website*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2016b). *My health, Queensland's future: Advancing health 2026*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2016c). *Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2026*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2016d). *Clinical Services Capability Framework website*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2017a). *Health and Wellbeing Strategic Framework 2017 to 2026*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2017b). *Advancing health service delivery through workforce: A strategy for Queensland 2017 to 2026*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2017c). *Advancing rural and remote health service delivery through workforce: A strategy for Queensland 2017–2020*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2017d). *Leadership Development Pathway*. Brisbane, QLD: Department of Health (Qld) – Prevention Division.

Queensland Health. (2017e). *Human Resource Policy G9: Performance and Development.* Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2017f). *Human Resource Policy G11: Performance Improvement*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2018a). *Human Resource Policy G6 (QH-POL-183): Orientation, induction and mandatory training*. Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2018b). *Nursing and Midwifery Education Model.* Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2018c). *Queensland Health Performance, Capability and Recognition website.* Brisbane, QLD: Department of Health (Qld).

Queensland Health. (2018d). *Queensland Health Guide for managers: Career Success Plan (CSP)*. Brisbane, QLD: Department of Health (Qld).

Queensland University of Technology (QUT). (2015a). *Advanced Standing Precedent List*.

Queensland University of Technology (QUT). (2015b). *Credit for Prior Learning*.

Quinn, F.M. & Hughes, S.J. (Eds.). (2013). *Principles and practices of Nurse Education (6th ed.)*. Cheltenham: Nelson Thornes Ltd.

Raban, B., Nolan, A., Waniganayake, M., Ure, C., Brown, R., & Deans, J. (2007). *Building Capacity Strategic professional development for early childhood practitioners.* Melbourne: Thomson Social Science Press.

Rafferty, A.M., Xyrichis, A. & Caldwell, C. (2015). *Post-graduate education and career pathways in nursing: a policy brief*. London, UK: King's College London.

Registered Nurses' Association of Ontario. (2007). *Professionalism in Nursing*. Toronto, Canada: Registered Nurses' Association of Ontario.

Registered Nurses' Association of Ontario. (2014). *Full and expanded scope of practice*. Toronto, Canada: Registered Nurses' Association of Ontario.

Reio, T. G., Jr. (2010). The ongoing quest for theory-building research methods articles [Editorial]. *Human Resource Development Review, 9*, 223-225.

Reio Jr, T.G., Rocco, T.S., Smith, D.H. & Chang, E. (2017). A Critique of Kirkpatrick's Evaluation Model. *New Horizons in Adult Education & Human Resource Development, 29*(2): 35-53.

Rennie, I. (2009). Exploring approaches to clinical skills development in nursing education. *Nursing Times, 105*(3): 20-22.

Riddle, D.D., Hoole, E.R. & Gullette, E.C.D. (Eds). (2015). *The Centre for Creative Leadership Handbook of Coaching in Organisations*. San Francisico, CA: Jossey Bass.

Rischel, C. (2013). Professional Development for Oncology Nurses: A Commitment to Lifelong Learning. *Oncology Nursing Forum, 40*(6), 537-539.

Ross, K., Barr, J. & Stevens, J. (2013). Mandatory continuing professional development requirements: what does this mean for Australian nurses. B*MC Nursing, 12*(9): 1-7. doi: 10.1186/1472-6955-12-9.

Rothwell, W.J. (2010). *Effective Succession Planning - Ensuring leadership continuity and building talent from within* (4th ed.). New York, NY: AMACOM – American Management Association.

Rush, K.L., Adamack, M., Gordon, J., Janke, R. & Ghement, I.R. (2013a). Orientation and transition programme component predictors of new graduate workplace integration. *Journal of Nursing Management, 2013*: 1-13.

Rush, K.L., Adamack, M., Janke, R. Gordon, J. & Ghement, I.R. (2013b). The helpfulness and timing of transition program education. *Journal for Nurses in Professional Development. 29*(4): 191-196.

Sawatzky, J.V. & Enns, C.L. (2009). A mentoring needs assessment: validating mentorship in nursing education. *Journal of Professional Nursing, 25*(3): 145-150.

Schmets, G., Rajan, D. & Kadandale, S. (Eds.). (2016). *Strategizing national health in the 21st century: a handbook.* Geneva: World Health Organization (WHO).

Schön, D. (1987). *Educating the Reflective Practitioner.* San Francisco: Jossey-Bass Inc., Publishers.

Schoonbeek, S. & Henderson, A. (2014). Shifting Workplace Behaviour to Inspire Learning: A Journey to Building a Learning Culture. *The Journal of Continuing Education in Nursing, 42*(1), 43-48.

Scott, C.L. (2015). The Futures of Learning 3: What kind of pedagogies for the 21st century? *Education Research and Foresight Working Papers*. Paris, France: United Nations Educational, Scientific and Cultural Organization (UNESCO).

Scottish Social Services Council (SSSC). (2014). *Mentoring: Supporting and Promoting Professional Development and Learning.*

Scottish Social Services Council (SSSC). (2016). *Supervision Learning Resource.*

Senge, P. M. (1990). *The fifth discipline: The art and practice of the learning organization*. New York: Doubleday/Currency.

Shinners, J.S. & Franqueiro, T. (2015). Preceptor skills and characteristics: Considerations for preceptor education. *The Journal of Continuing Education, 46*(5): 233-236.

Shuffler, M.L., Salas, E. & Xavier, L.F. The design, delivery and evaluation of crew resource management training. In E.L. Wiener, B.G. Kanki, R.L. Helmreich & J.M. Anca Jr. (Ed.). *Crew Resource Management* (pp. 205-232). San Diego, CA: Elsevier Science & Technology.

Simmonds, P. (2003). Continuing professional development and workplace learning 2: CPD and you – how CILIP is meeting the continuing professional development needs of its members. *Library Management, 24*(3): 169-170. doi: 10.1108/01435120310464899.

Sjukhusläkaren (2005). Policy statement on continuing medical education and continuing professional development [Online].

Skees, J. (2010). Continuing education: A bridge to excellence in critical care nursing. *Critical care Nursing Quarterly, 33*(2): 104-116.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S. & Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1): 12-20.

South African Qualifications Authority (SAQA). (2015). *Continuing Professional Development (CPD) Practices in Recognised Professional Bodies.* Pretoria, South Africa: SAQA.

South Australia (SA) Health. (2014). *Nursing and Midwifery Capability and Self Development Framework.* Adelaide, SA: Government of South Australia.

Spacey, J. (2017). 8 Types of Organizational Knowledge. *Simplicable*.

Stella, S. (2012). *Lifelong Learning - Education and Training - Learning and Teaching Methodology*, FIG Working Week 2012, Knowing to manage the territory, protect the environment, evaluate the cultural heritage. Rome, Italy, May 2012, 6-10.

Stoll, L. (2004). Leadership learning: Designing a connected strategy, IARTV Seminar Series Paper, 135: August, IARTV.

SuccessFactors. (2018). *Importance of performance management process & best practices to optimize monitoring performance work reviews/feedback and goal management.* Sydney, NSW: SAP Company.

Sweeney, B. (2013). *Success through Succession: A Review of Recent Literature.* Queen's University IRC: Ontario, Canada.

Sydney Local Health District (SLHD). (2017). Clinical Nurse/Midwifery Educator Professional Development Pathway (2nd ed.). Sydney, NSW: NSW Government.

Tetrick, L.E. & Camburn, M.K. (2004). Organizational Structure. *Encyclopedia of Applied Psychology, 2004*: 747-753.

Thorne, S.E. (2006). Nursing Education: Key Issues for the 21st Century. *Nurse Education Today, 26*: 614-621.

Tight, M. (1996). *Key Concepts in Adult Education and Training,* London: Routledge.

Tiwaken, S.U., Caranto, L.C. & David, J.J.T. (2015). The Real World: Lived Experiences of Student Nurses during Clinical Practice. *International Journal of Nursing Science, 5*(2): 66-75. doi: 10.5923/j.nursing.20150502.05.

Trede, F., Sutton, K. & Bernoth, M. (2015). Conceptualisations and perceptions of the nurse preceptor's role: A scoping review. Nurse Education Today, 36(Jan): 268-274.

Underhill, M. (2017). Succession planning: Are you innovative or stuck in the mud? *HRM* (4 January 2017). Melbourne, VIC: Australian HR Institute.

University of New South Wales (UNSW). (2015). Academic Mentoring Program – Guidelines for participants. Kensington, NSW: UNSW.

University of Southern Queensland (USQ). (2004). *Evaluation in Instructional Settings Study Book*. Toowoomba, QLD: USQ.

Valizadeh, S., Borimnejad, L., Rahmani, A., Gholizadeh, L. & Shabazi, S. (2016). Challenges of the preceptors working with new nurses: A phenomenological research study. *Nurse Education Today, 44*(9): 92-97.

Victorian Public Sector Commission. (2015). Great managers, great results: *Development framework for Victorian Public Sector Managers*. Melbourne: Victorian State Government.

Ward, A. & McComb, S. (2017). Precepting: A literature review. *Journal of Professional Nursing, 33*(5): 314-325.

Wendler, M.C., Olson-Sitki, K. & Prater, M. (2009). Succession planning for RNs: implementing a nurse management internship. *Journal of Nursing Administration, 39*(7-8): 326-333.

Weselby, C. (2014). Nurse Preceptor: A Vital Role. *Wilkes University Nursing Community Journal*.

White, D., Oelke, N.D., Besner, J., Doran, D., McGillis Hall, L. & Giovannetti, P. (2008). Nursing Scope of Practice: Descriptions and Challenges. *Nursing Leadership, 21*(1): 44-57.

Whitehead, B., Owen, P., Holmes, D., Beddingham, E., Simmons, M., Henshaw, L., Barton, M. & Walker, C. (2013). Supporting newly qualified nurses in the UK: a systematic review of the literature. *Nurse Education Today*. 33(4): 370-377.

Whitehead, B., Owen, P., Henshaw, L., Beddingham, E. & Simmons, M. (2015). Supporting newly qualified nurse transition: A case study in a UK hospital. Nurse Education Today, 36(1): 58-63.

Whitehead, D., Welch Dittman, P. & McNulty, D. (2017). Leadership and the Advanced Practice Nurse: The Future of a Changing Health-Care Environment. Philadelphia, PA: F.A. Davis Company.

Williams, J. & Rosenbaum, S. (2004). *Learning Paths Increase Profits by Reducing the Time it Takes Employees to Get Up-To-Speed*. San Francisco: Pfeiffer.

Young, L., & Patterson, B. (Eds). (2007). Teaching nursing. Developing a student centered learning environment. Philadelphia, PA: Lippincott Williams & Wilkins.

Queensland
Government

Performance

Sustainable

Support

Goals

Succession

Guide

Opportunities

Management &

Mentoring Manual & Toolkit

Career

Talent

Pathway

for Nurses

Foster

& Midwives

Development

June 2019

Excellence

Professional

Engagement

Potential

Culture

Capability

Queensland Government

Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives

Published by the State of Queensland (Queensland Health), June 2019

For more information contact:
Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Queensland, Department of Health, GPO Box 48, Brisbane Qld 4001, email chiefnurse-office@health.qld.gov.au.

An electronic version of this document is available at:
https://qheps.health.qld.gov.au/nmoq/professional-capability

Disclaimer:

The content presented in this publication is distributed by the Queensland Government as an information source only. The State of Queensland makes no statements, representations or warranties about the accuracy, completeness or reliability of any information contained in this publication. The State of Queensland disclaims all responsibility and all liability (including without limitation for liability in negligence for all expenses, losses, damages and costs you might incur as a result of the information being inaccurate or incomplete in any way, and for any reason reliance was placed on such information.

Authors

Beth McCauley	Project Officer (Nurse Educator), Nursing and Midwifery Education and Workforce, Office of the Executive Director Nursing and Midwifery Metro North Hospital and Health Service (MNHHS)
Robyn Fox	Professor of Nursing and Midwifery Professional Education and Workforce Development, Office of the Executive Director Nursing and Midwifery MNHHS
Christine Burridge	Nursing & Midwifery Director, Education, Office of the Executive Director Nursing and Midwifery MNHHS

Acknowledgements

The authors of this Version of the *Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives – Queensland Health* (2019) (Manual & Toolkit) wish to acknowledge:

- project sponsor and executive leadership provided by Adjunct Professor Alanna Geary, Executive Director Nursing & Midwifery, Metro North Hospital and Health Service
- sponsorship and professional support provided by the Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division – Department of Health
  - Shelley Nowlan, Chief Nursing and Midwifery Officer, Queensland Health
  - Michelle Gunn, Director of Nursing, Professional Capability, Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division
- the original authors, reviewers and editors of the *Framework for Lifelong Learning for Nurses and Midwives – Queensland Health (2018)*, in particular, the work undertaken by Robyn Fox, Catriona Booker and Adam Turbutt in collaboration with Queensland Hospital and Health Service nursing and midwifery colleagues
- the following HHSs for the provision of existing resources that have been used to inform this Manual & Toolkit:
  - Metro North
  - Darling Downs
  - Sunshine Coast
  - Children's Health Queensland
  - Gold Coast
  - Central Queensland.
- Catriona Booker, Acting Nursing Director Education, Royal Brisbane and Women's Hospital (RBWH) MNHHS
- Specialist Subject Matter and/or Diagrammatical Contributions by:
  - Catriona Booker, Acting Nursing Director Education, Royal Brisbane and Women's Hospital (RBWH) MNHHS
  - Adam Turbutt, Nurse Educator, RBWH MNHHS
  - Allison Bowen, Nursing Director Education, Redcliffe Hospital MNHHS

Editorial Committee:

Metro North Hospital and Health Service

- Christine Burridge – Nursing and Midwifery Director, Education
- Robyn Fox – Professor of Nursing and Midwifery, Professional Education and Workforce Development

Metro South Hospital and Health Service

- Bernadette Thomson – Nursing Director Education, Princess Alexandra Hospital

Children's Health Queensland Hospital and Health Service

- Kim Anderson – Acting Nursing Director Learning and Workforce Development, Queensland Children's Hospital

Wide Bay Hospital and Health Service

- Rikki-Lee Arnicar – Clinical Placement and Graduate Nurse Coordinator, Bundaberg BaseHospital

Mackay Hospital and Health Service

- Karen Wade – Nursing Director Education and Research, Mackay BaseHospital

Sunshine Coast Hospital and Health Service

- Annette Faithfull-Byrne – Nursing Director Education Staff Development and Research, Sunshine Coast University Hospital

Torres and Cape Hospital and Health Service

- Sophia Rodert – Nurse Educator, Weipa Integrated Health Service

North West Hospital and Health Service

- Paula Gittins – Nurse Educator Remote Health & Student Placements, Mount Isa Hospital

South West Hospital and Health Service

- Leanne Raatz – Nursing Director Education

Darling Downs Hospital and Health Service

- Carolyn Bourke – Nurse Manager Clinical Workforce Development, Baillie Henderson Hospital Toowoomba

Cairns and Hinterland Hospital and Health Service

- Rachelle Cooke – Acting Associate Nursing Director Workforce, Cairns Hospital
- Shaun Cram – Nurse Educator, Nursing Education, Mossman Hospital

Townsville Hospital and Health Service

- Catherine Betcher – Nurse Educator Clinical Education, Townsville Hospital

Central Queensland Hospital and Health Service

- Julie Kahl – Nursing Director Education and Research, Rockhampton Hospital

West Moreton Hospital and Health Service

- Ruth McCaffery – Nursing Director, Education and Research, Ipswich Hospital

Gold Coast Hospital and Health Service

- Susanne Pearce – Assistant Director of Nursing Entry to Practice, Gold Coast University Hospital

Central West Hospital and Health Service

- Donna Hovey – Nurse Educator, Longreach Hospital

Retrieval Services Queensland

- Pauline Calleja – Nurse Educator, Education Support Team

Steering Committee:

Metro North Hospital and Health Service

- Christine Burridge – Nursing and Midwifery Director, Education
- Robyn Fox – Professor of Nursing and Midwifery, Professional Education and Workforce Development

Metro South Hospital and Health Service

- Bernadette Thomson – Nursing Director Education, Princess Alexandra Hospital

Children's Health Queensland Hospital and Health Service

- Kim Anderson – Acting Nursing Director Learning and Workforce Development, Queensland Children's Hospital

Wide Bay Hospital and Health Service

- Rikki-Lee Arnicar – Clinical Placement and Graduate Nurse Coordinator, Bundaberg Base Hospital

Mackay Hospital and Health Service

- Karen Wade – Nursing Director Education and Research, Mackay Base Hospital

Sunshine Coast Hospital and Health Service

- Annette Faithfull-Byrne – Nursing Director Education Staff Development and Research, Sunshine Coast University Hospital

Torres and Cape Hospital and Health Service

- Sarah Worth – Director of Nursing Clinical Education

North West Hospital and Health Service

- Paula Gittins – Nurse Educator Remote Health & Student Placements, Mount Isa Hospital

South West Hospital and Health Service

- Leanne Raatz – Nursing Director Education, Roma Hospital

Darling Downs Hospital and Health Service

- Carolyn Bourke – Nurse Manager Clinical Workforce Development, Baillie Henderson Hospital Toowoomba

Cairns and Hinterland Hospital and Health Service

- Jenny Sando – Nursing Director Education/ Research, Cairns Hospital

Townsville Hospital and Health Service

- Catherine Betcher – Nurse Educator Clinical Education, Townsville Hospital

Central Queensland Hospital and Health Service

- Angela Parsons – Nurse Educator Education and Research, Rockhampton Hospital

West Moreton Hospital and Health Service

- Josh Lovell – Nurse Educator, Education and Research, Ipswich Hospital

Gold Coast Hospital and Health Service

- Brenton Shanahan – Assistant Director of Nursing Education Programs, Gold Coast University Hospital

Central West Hospital and Health Service

- Donna Hovey – Nurse Educator, Longreach Hospital

Retrieval Services Queensland

- Pauline Calleja – Nurse Educator, Education Support Team

Overarching Caveats

- The *Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives* should be used and applied in conjunction with the *Framework for Lifelong Learning for Nurses and Midwives*.
- The terms 'person-centred' and 'consumer' have been used throughout the *Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives* and other supporting resources to reflect the care philosophy within both the nursing and midwifery professions.
- While it is acknowledged that the term 'specialisation' can be applied in a variety of contexts, please note that within the Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives and other supporting resources, the midwifery profession is less likely to apply the term 'specialisation' in practice. As such, the term 'specialisation', and sections referring to 'specialisation' are only to be applied to the nursing profession.
- The Office of the Chief Nursing and Midwifery Officer is responsible for the development of Midwifery Career Pathways and Classification Structure. Future versions of the *Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives* and other supporting resources will reflect any amendments to the Midwifery Career Pathways. In the interim, current resources can be applied as relevant to support the midwifery profession.
- The term Performance and Development Planning (PDP) has been used to describe the process whereby nurses/midwives and respective line managers discuss and plan an individual's development throughout the *Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives* to align with the *Framework for Lifelong Learning for Nurses and Midwives*.
- The principles and tenets of the Succession Management & Mentoring Manual & Toolkit for Nurses & Midwives can be contextualised for use by nursing and midwifery in any Queensland Health HHS and other professions.

Table of Contents

Authors....3

Acknowledgements....3

Table of Contents....6

1. Intent....8

2. Glossary....8

3. Background....8

4. Assumptions....8

5. Applicability....9

6. Succession Management....10

6.1 Advantages of Succession Management....10

6.2 Barriers to Succession Management....11

6.3 Succession Planning and Management Approaches....11

6.3.1 Emergency Replacement Approach....11

6.3.2 Target Date/Management Driven Replacement Approach....12

6.3.3 Talent Pool Approach....12

6.3.4 Top-Down/Bottom-Up Approach....12

6.4 Succession Management Phases....13

6.4.1 Phase 1 – Identification....13

6.4.2 Phase 2 – Development....15

6.4.3 Phase 3 – Outcomes....17

7. Mentoring....18

7.1 Related Supportive Developmental Relationships....18

7.2 Informal and Formal Mentoring Relationships....19

7.3 Mentoring Models....20

7.4 Advantages of Mentoring....21

7.4.1 Advantages for the Mentor....21

7.4.2 Advantages for the Mentee....21

7.4.3 Advantages for the HHS/Facility....22

7.5 Barriers to Mentoring Success....22

7.6 Roles, Responsibilities and Expectations....23

7.6.1 Roles, Responsibilities and Expectations of the Mentor....23

7.6.2 Roles, Responsibilities and Expectations of the Mentee....25

7.6.3 Roles, Responsibilities and Expectations of the Line Manager....25

7.6.4 Roles, Responsibilities and Expectations of the Mentoring Coordinator/Champion/

Delegate (if sponsored) 26
7.7 The Mentoring Journey 26
7.7.1 Phase 1 – Recognition and Development 27
7.7.2 Phase 2 – Enabling and Emerging Independence 29
7.7.3 Phase 3 – Conclusion of Formal Relationship 30
7.8 Managing an Ineffective Mentoring Relationship 31
Succession Management & Mentoring Toolkit 33
Succession Management Resources 34
Career Pathway Self-Assessment Activity 35
Career Development Opportunities in the Workplace 37
Mentoring Toolkit 39
Mentor & Mentee Partnership Agreement 40
Meeting Journal Sheet 41
Reflective Journal Sheet 42
Mentor Expression of Interest 43
Mentor Initial Self Reflection 44
Mentor Conversation Starter Guide 45
Mentor Evaluation Tool (Periodic) 47
Mentor Evaluation Tool (Final) 48
Mentee Expression of Interest 49
Mentee Initial Self Reflection 50
Mentee Evaluation Tool (Periodic) 51
Mentee Evaluation Tool (Final) 52
Appendices 53
Appendix 1: Glossary 53
Appendix 2: 56
Standards for Succession Management 56
Standards for Mentoring 57
Appendix 3: Nursing and Midwifery Education Model – Example 58
Appendix 4: Broad Concepts of Generic Learning Pathways 59
Appendix 5: Diagrammatic Representation of Succession Management 60
Appendix 6: Succession Management and PDP Flowchart 61
Appendix 7: Mentoring Process Flowchart 62
Appendix 8: Mentor and Mentee Characteristics, Abilities and Attitudes 63
References 64

1. Intent

The primary focus of the Succession Management & Mentoring Manual & Toolkit (Manual & Toolkit) is to support nurses and midwives (nurses/midwives) to take responsibility for, and proactively manage, their career and its trajectory. The Manual & Toolkit aim to promote and facilitate statewide effective planning, implementation and evaluation of succession management and mentoring initiatives to build nursing/midwifery workforce capacity and capability across Queensland Health (QH) to effectively fulfil career pathway expectations and vacancies within the context of practice in Hospital and Health Services (HHS)/facilities.

To support application of the key tenets of succession management and mentoring, the Manual & Toolkit has been divided into three sections:

- Succession Management
- Mentoring
- Succession Management & Mentoring Toolkit.

2. Glossary

A Glossary (Appendix 1) has been provided to clarify the terms used within the Manual & Toolkit pertinent to nursing/midwifery and promote appreciation for consistent terminology used within the professions. Given that many terms relating to the workplace, supportive and developmental relationships and continuing professional development (CPD) are often used interchangeably, the glossary is an important resource to avoid confusion and assist users with the correct application of shared language and the application of the *Framework for Lifelong Learning for Nurses and Midwives Queensland Health – June 2018* (*The Framework*) and Manual & Toolkit tenets and terms (refer to **Appendix 1, pages 69–73, of *The Framework***).

3. Background

The Australian healthcare workforce is facing significant challenges with workforce projections indicating that in the medium- to long-term future, the demand for nurses/midwives in Australia will significantly exceed supply (Health Workforce Australia, 2012, 2014). Effective succession management and advocacy for supportive and developmental relationships (e.g. mentoring) is critically important in light of these workforce challenges. These strategies contribute to the development of a sustainable nursing/midwifery workforce that attains the requisite knowledge and skills to be eligible for desirable roles when vacancies arise or when models of care change (Booker, Turbutt, & Fox, 2016; Kallmeyer & Martin, 2018; Sibbald, Wathen, & Kothari, 2017). Further, mentorship opportunities for nurses/midwives who have potential and talent that may already, or could be, developed to be competent and qualified replacements when vacancies occur is essential (Vanvactor, 2015). There is a plethora of literature that supports the requirement for the implementation of succession management and mentoring strategies to develop willingness and enthusiasm in nurses/midwives who seek to advance or develop their career (Deloitte, 2016; Griffith, 2016; Pedersen et al., 2018; Stone & Deadrick, 2015).

This Manual & Toolkit is predicated on *The Framework* (Section 12 [Supporting Relationships to Build Capacity], refer to **pages 49–59 of *The Framework***), which is the overarching resource providing the scaffold for teaching and learning considerations that contribute to the development of a sustainable, professional, capable and person-centred nursing/midwifery workforce (Queensland Health, 2018a). The Standards for Succession Management and Mentoring and diagrammatic models contained within *The Framework* have been included in Appendix 2 and Appendix 3. The Nursing and Midwifery Career Pathways (Career Pathways) (refer to **Section 8.2.1, pages 22–23, of *The Framework***) and Orientation to Role Packages should be used simultaneously with succession management and/or mentoring strategies to promote and support organisational processes for career planning and development (Queensland Health, n.d.).

4. Assumptions

- A culture of lifelong learning is promoted and championed to enhance support for, and the application of, the tenets of Section 12 within *The Framework* by nursing/midwifery across HHSs/facilities (Darling Downs Hospital and Health Service [DDHHS], 2018; Scottish Social Services Council [SSSC], 2014) (refer to **Section 12, pages 49–59, of *The Framework***).
- HHSs/facilities support workforce planning and development to enhance clinical, education, leadership, system support and research role potential that align with the strategic direction of the nursing/midwifery profession and employee career aspirations.

- HHSs/facilities value a sustainable, competent and capable nursing/midwifery workforce that is encouraged to participate in succession management and mentoring strategies by providing opportunities to establish goals and career/professional development pathways (Queensland Health, 2015).
- HHSs/facilities contribute to the development of a sustainable and competent nursing/midwifery workforce that can effectively function in clinical, education, leadership, system support and research nursing/midwifery roles (DDHHS, 2018).
- HHSs/facilities aim to decrease the impact of loss of professional, technical and corporate knowledge, skills, abilities and experience as a result of attrition of experienced nursing/midwifery employees.
- Nursing/midwifery employees seek opportunities to enhance their career development and demonstrate advanced professional knowledge, skills, attitudes and abilities to improve the quality of person-centred consumer care and contribute to best practice outcomes (Metro North Hospital and Health Service [MNHHS], 2015a).
- HHSs/facilities promote and facilitate strategies to enhance the establishment of formal and informal support networks for the nursing/midwifery profession.
- The tenets of Performance and Development Planning (PDP) underpin succession management and mentoring strategies and processes required by individual nurses/midwives within HHSs/facilities (refer to **Section 13, pages 60–62, of *The Framework***).
- Nurses/midwives actively participate in PDP discussions with their line managers.
- The Career Pathways, Orientation to Role Packages and Succession Management & Mentoring Manual & Toolkit are accessible and used within HHSs/facilities to build nursing/midwifery workforce capacity and capability to support the fulfilment of career pathway expectations and mitigate the implications of nursing/midwifery vacancies (refer to **Section 8.2.1, page 22 and Section 12, page 49, of *The Framework***).
- Mentor, mentee, line manager and HHS/facility mentoring coordinator/champion/delegate (if sponsored) roles and responsibilities are considered.
- The nursing/midwifery profession fosters interprofessional networks, education and engagement.

5. Applicability

The Manual & Toolkit focuses on supporting and enhancing nursing/midwifery capacity and capability building to equip the healthcare system for the future. The Manual & Toolkit can be used and supported by nursing/midwifery groups and individuals, including, but not limited to:

- **Nursing/midwifery leadership** (e.g. Office of Chief Nursing and Midwifery Officer Queensland, Executive Directors Nursing/Midwifery, Directors of Nursing/Midwifery, Nursing/Midwifery Directors and Assistant Nursing/Midwifery Directors) who support collective engagement in the development, education and training of nurses/midwives to achieve a sustainable, professional, capable and person-centred workforce.
- **Line managers** (e.g. Nurse/Midwifery Unit Managers) who facilitate continuity and sustainability of operational services, maintain productivity and standards and achieve effective recruitment and retention of high potential and performing nurses/midwives.
- **Resource and support persons** (e.g. Nurse/Midwifery Educators, Clinical Nurse/Midwifery Consultants, Clinical Nurses/Midwives – Clinical Facilitators, Preceptors and Mentors) who facilitate opportunities for nursing/midwifery career development and direction.
- **Nursing/midwifery employees** who proactively manage their career development by identifying and implementing strategies to support achievement of personal, professional and career development goals. Further, nursing/midwifery employees who engage in supportive and developmental relationships and recognise the organisational and professional expectations for specific positions and align these with HHS strategic direction and operational imperatives (MNHHS, 2015a).

6. Succession Management

It has been noted that five generations coexist within the nursing/midwifery profession and workplace (Acree-Hamann, 2016). As Traditionalists and Baby Boomers are leaving the workforce, Generation Z is eagerly joining (Warshawsky & Martin, 2017). Hence, effective succession management is a priority for healthcare organisations due to the global nursing shortage and the imminent retirement of the Traditionalist and Baby Boomer generations (Griffith, 2012; Manning, Jones, Jones, & Fernandez, 2015). Given

many nursing/midwifery leaders and clinicians are in this generational cohort, their retirement will have an impact on workforce supply (Denker, Sherman, Hutton-Woodland, Brunell, & Medina, 2015; Warshawsky & Martin, 2017). Similarly, this generational cohort have unique skills and abilities that are critical to organisational success (Stone & Deadrick, 2015).

The key challenge for nursing/midwifery leaders now, and in the future, is to predict the knowledge, skills and abilities that are required to continue leading healthcare organisations effectively and sustainably (West, Smithgall, Rosler, & Winn, 2016). Effective succession management by current leaders will ensure that there is a qualified, capable and competent pool of nursing/midwifery talent ready to fill positions when anticipated clinical, education, leadership, system support and research vacancies occur (Griffith, 2012; West et al., 2016).

Workforce planning is fundamental to the efficient operation and sustainability of an organisation. It underpins talent management and succession planning by identifying and defining the competencies and capabilities required for an organisation to effectively function (Government of Western Australia – Department of Training and Workforce Development, n.d.). Talent management is the process of identifying and developing key employees that possess the desirable knowledge, skills and abilities, with the focus on retaining essential capabilities within the workforce to maintain competitiveness. It is important that talent management and workforce planning strategies align with the strategic workforce plan. By embracing the concept of talent management and implementing an attraction strategy, HHSs/facilities can support their workforce to be prepared and responsive to current and future workforce requirements (Martin, 2015). HHSs/facilities with effective succession planning and management strategies can appreciate and derive benefit from the advantages associated with the identification of successor candidates to fill key clinical, education, leadership, system support and research positions within the nursing/midwifery workforce (Webb, Diamond-Wells, & Jeffs, 2017).

6.1 Advantages of Succession Management

An organisational culture that encourages individual career development and promotes professional development is essential. Organisations that invest in the professional development of their employees will benefit from return on expectation and investment (Jones, 2019). Effective succession management encourages individual nurse/midwife career development and goal attainment, in addition to the creation and sustainability of a pool of talented nursing/midwifery employees who attain the skills, knowledge and attitudes required to become competent professionals (Griffith, 2012).

There are various advantages associated with the successful application of succession management strategies within healthcare (Webb et al., 2017):

- nurses/midwives who can contribute to workforce sustainability are identified (MNHHS, 2015a)
- nurses/midwives who have career development and direction goals are attracted and retained (CPS HR Consulting, 2017; Manning et al., 2015; Titzer & Shirey, 2013; Titzer, Shirey, & Hauck, 2014)
- a pool of qualified, promotable and prepared nurses/midwives are available for appointment to unexpected or future clinical, education, leadership, system support and research position vacancies (CPS HR Consulting, 2017; Phillips, Evans, Tooley, & Shirey, 2018)
- there are improvements in employee job satisfaction and organisational commitment (CPS HR Consulting, 2017; Manning et al., 2015; Titzer, Phillips, Tooley, Hall, & Shirey, 2013)
- there is a reduction in employee turnover, and recruitment and replacement costs (CPS HR Consulting, 2017; Manning et al., 2015; Phillips et al., 2018; Titzer et al., 2013).

A commitment to succession management is demonstrated by a proactive and visionary leadership approach and an ongoing analysis of anticipated future HHS/facility needs (Titzer & Shirey, 2013). Nursing/midwifery workforce supply is unlikely to be maintained or enhanced when barriers to succession management are present (Griffith, 2012).

6.2 Barriers to Succession Management

To mitigate the concerns associated with absent or poor succession management processes, succession management needs to be embedded within a HHS/facility's core business and openly communicated for broader situational awareness

(Vanvactor, 2015). Prior to the development, implementation and support of a succession management program and/or strategies, an awareness of the potential barriers to success is essential for leaders and managers (Titzer et al., 2013). Potential barriers may include:

- HHS/facility failure to recognise the need for, and benefits of, succession management
- leader/manager assumption that nurses/midwives are prepared and willing to take on positions
- leader/manager reluctance to develop internal nurses/midwives with potential due to fear that they will seek advancement opportunities elsewhere
- leader/manager resistance to readily share their knowledge, expertise and experiences with potential successors (Titzer et al., 2013)
- a lack of role clarity for aspiring nursing/midwifery potential succession management candidates (Kallmeyer & Martin, 2018; Titzer et al., 2013)
- limited opportunity for nursing/midwifery promotion due to size of the HHS/facility
- a lack of funding to attract and maintain nursing/midwifery workforce talent
- a lack of interest in clinical, education, leadership, system support and research positions by potential succession management candidates
- negative views by leaders/managers of their work and roles which consequently discourages aspiring employees (Fray & Sherman, 2017)
- perceived difficulty in finding time to learn and acquire the relevant skills and knowledge for aspiring role by potential succession management candidates (Titzer et al., 2013)
- when succession management is not underpinned by or linked to an employee's PDP (refer to **Section 13, pages 60–62, of *The Framework***)
- when potential succession management candidates have not completed, or are not motivated to complete, the appropriate program of study at a relevant Australian Qualification Framework (AQF) level for the desirable nursing/midwifery classification or role (Kallmeyer & Martin, 2018) (refer to **Appendix 3, pages 75–77, of *The Framework***).

A formal succession management program and/or support of strategies can demonstrate HHS/facility commitment to nursing/midwifery career development and professional advancement (Brunero, Kerr, & Jastrzab, 2009). However, given there is still confusion regarding the succession planning and management approaches within healthcare, it is important for leaders and managers to understand each approach and the anticipated expectations and outcomes (MNHHS, 2015a).

6.3 Succession Planning and Management Approaches

There is not a 'one size fits all' approach to succession planning and management for HHSs/facilities that wish to develop potential succession management candidates. The approach to succession planning and management needs to be situational, and depends on the context, resources and specific needs of the HHS/facility at the time. Furthermore, succession planning and management approaches may evolve while a HHS/facility identifies what works well and the required improvements (Treasury Board of Canada, 2012). To assist nursing/midwifery stakeholders in understanding the succession planning and management approaches commonly used within healthcare, the approaches have been further discussed.

6.3.1 Emergency Replacement Approach

The requirement for emergency replacement is often perceived as a result of poor succession planning processes. This approach is reactive and involves the immediate assessment of available and qualified candidates for vacancies (Titzer & Shirey, 2013). Emergency replacement planning focuses on reducing the impact caused by the unexpected or immediate loss of a key position, or the expansion of service provision within a HHS/facility. The risks associated with emergency replacement include the loss of knowledge and skills caused by the exit of the experienced employee and the consequent reduction in productivity and cost of training for the newly appointed replacement candidate/s (MNHHS, 2015a).

6.3.2 Target Date/Management Driven Replacement Approach

Target date succession planning is used when a potential vacancy is identified in advance. This strategy allows the HHS/facility to proactively identify potential replacement candidates and ensure that they receive the appropriate

education, training, coaching and/or mentoring to prepare them for the position before recruitment commences (Lohrey, 2019). This strategy generally involves the incumbent identifying an employee who they deem suitable to move into their position. The incumbent will likely identify the developmental needs of the selected employee and engage in a professional relationship to prepare them to take on the role. This strategy is likely the most efficient and economically suitable approach to succession planning (MNHHS, 2015a). However, there are various risks associated with this approach, including:

- the incumbent may only identify individuals that are most like themselves or who display similar traits, behaviours and ideas resulting in:
  - reduced workforce diversity
  - unfamiliarity of available employees within large HHSs/facilities
- person/s identified do not aspire to the position
- person/s identified leave the HHS/facility prior to accepting the position (MNHHS, 2015a).

6.3.3 Talent Pool Approach

The creation of a talent pool within a HHS/facility ensures that a qualified group of employees with varying qualifications are available to undertake clinical, education, leadership, system support and research roles once vacancies are available (Griffith, 2012). Employees within a talent pool are usually selected through interview or an evaluation process by a panel of senior managers/leaders, generally with the assistance of Human Resources (MNHHS, 2015a). Talent pools complement succession planning strategies as they provide flexibility and allow for the development of talent in areas that match HHS/facility needs, skills, abilities, attitudes and values (Talent Guard, 2018). This strategy also saves time and money given hiring internally often shortens the recruitment timeline and is less costly than recruiting external candidates (Lohrey, 2019). Furthermore, this process minimises disruption to HHS/facility function (Griffith, 2012). There are three strategies that need to be considered for employees within a talent pool:

1. **Development:** Employees need to be adequately prepared for movement or advancement.
2. **Regular assessment of performance:** Assessment of performance will ensure that employees attain the required competencies, knowledge and skills for success in the assigned position.
3. **Promotion or re-assignment:** When vacancies arise, the talent pool should be referred to for potential candidate/s (Saba, 2019).

This succession planning approach is generally fairer than that of target replacement/management driven succession planning as managers are involved in the selection of candidates and it involves application of the same selection criteria. However, the disadvantage of this approach is that candidate selection may be influenced by their visibility and familiarity to the selection panel resulting in discouragement, demoralisation and resentment by employees within the talent pool who were not chosen to fill the vacancy (MNHHS, 2015a).

N.B If HHSs/facilities have difficulty in establishing a talent pool due to restrictions relating to location or resources, it is recommended that they consider establishing partnership/s with other HHSs/facilities to facilitate this approach.

6.3.4 Top-Down/Bottom-Up Approach

The top-down/bottom-up approach is based on the current and projected needs of a HHS/facility and involves the establishment of an ongoing two-way communication line between the line manager and the employee. It is a transparent process whereby employees are empowered to take control of, and be accountable for, their career development and trajectory. Furthermore, the strategy creates opportunities for a broad group of employee participation and a reduced chance of conflict given decisions are based on merit (MNHHS, 2015a). The top-down/bottom-up approach generally involves:

- consideration of future HHS/facility requirements by taking into account the extent of workforce shortages
- identification of key skill sets and capacity building requirements by executives and senior managers
- encouragement for employees to participate in succession management/career development opportunities by line managers
- employees nominating their interest to participate in succession management/career development opportunities and the subsequent monitoring of employee development and performance through the PDP process
- support of succession management and career development opportunities and the development and implementation of

individually tailored professional/career development plans
- identification of employee strengths and developmental needs through self-assessment against role-related key skill sets and line manager appraisal
- employing individuals into positions based on merit, where consideration is given to job performance, experience, qualifications and assessment of potential for a specific job (MNHHS, 2015a).

HHSs/facilities with established succession planning and management processes can successfully and efficiently identify potential replacement candidates to fill vacant positions (Queensland Health, 2018a). Regardless of the approach used by a HHS/facility, line managers are responsible for engaging in open and honest dialogue with nursing/midwifery employees regarding their developmental needs, succession management potential and opportunities for career goal achievement (Queensland Health, 2018a).

6.4 Succession Management Phases

Each succession planning and management approach used by line managers integrates the phases of identification, development and the evaluation of outcomes to facilitate the growth, replacement and strategic application of potential nursing/midwifery succession management candidates. The three phases support HHSs/facilities to identify and develop candidates to fulfil critical positions and subsequently improve nursing/midwifery workforce capacity and capability (Deloitte, 2016). The Succession Management Model (Appendix 5) contained within *The Framework* has been included within this Manual & Toolkit as it provides a diagrammatic representation of the phases of succession management (refer to **Section 12, page 58, of *The Framework***). As depicted in the model, facility/directorate/service strategic and operational action plans and *The Framework* support succession management strategies and processes. The model has been provided as a broad example of the succession management pathway and should be adapted to align with current HHS/organisational processes following consideration of context and resource availability. Moreover, the processes contained within the model should be contextualised to a nurse/midwife's individual career development trajectory.

6.4.1 Phase 1 – Identification

Phase 1 of the succession management pathway encompasses the identification of critical positions, recognition of their associated values, skill set and capacity building requirements and developing potential candidates within a HHS/facility using the PDP Agreement, Career Pathways and career development opportunities. To assist the user to understand and appreciate the components of Phase 1, each section has been individually considered and discussed.

Key/Critical Positions/Roles and Responsibilities

The identification of key/critical positions is an important driver of succession management as it supports HHSs/facilities to effectively allocate developmental training resources to facilitate continuity and mitigate the consequences of employee attrition (Children's Health Queensland Hospital and Health Service [CHQHHS], 2015a; Higginbottom, 2014).

A nursing/midwifery position is considered key or critical if it:

- is a primary contributor to the achievement of the organisation's mission, vision and strategic goals
- performs, or is heavily involved in performing, critical tasks that would cease or obstruct vital organisational function/s if it were to be left vacant
- requires specialised or unique expertise that is considered difficult to replace
- is unique in a geographical location and it would be considered difficult to have a similar position execute the same function/s at a different location (CHQHHS, n.d.).

The recognition of key/critical nursing/midwifery positions for succession management should include all streams of nursing/midwifery using the principles contained within the Broad Concepts of Generic Learning Pathways Model (Appendix 4), including clinical, education, leadership, system support and research (refer to **Section 8.2.2, page 26, of *The Framework***). Upon recognition of key/critical positions, HHSs/facilities are encouraged to advertise Expressions of Interest (EOI) globally via appropriate channels (e.g. email) to identify nurses/midwives with an interest in being appointed to the position (MNHHS, 2015a).

Once key/critical positions have been recognised, the specific key values, skill set and capacity building requirements that are desirable for each position need to be identified (Central Queensland Hospital and Health Service [CQHHS], n.d.).

Key Values, Skill Sets and Capacity Building Requirements

Key skill sets are the core skills, knowledge and abilities required to perform in a particular position (MNHHS, 2015a). The organisational assessment and identification of the key values, skill set and capacity building requirements assist to determine the existing bench strength within the organisation (CQHHS, n.d.). Nursing/midwifery employees can use role descriptions and a Career Pathway to facilitate the identification of the key values, skill set and capacity building requirements for an aspiring role.

Role descriptions are valuable resources that provide nurses/midwives with the defined explanations of role classification expectations, responsibilities, values, knowledge, skills and professional standards/competencies and aligned standards of performance. Additionally, the Career Pathways (refer to **Section 8.2.1, pages 22–23, of *The Framework***) incorporate the clinical, professional and organisational expectations and responsibilities of specific nursing/midwifery roles. Role descriptions and a Career Pathway can assist nursing/midwifery employees to identify their strengths and career development requirements with regard to the key values, skill set and capacity building requirements for their aspiring role in collaboration with their line manager and/or mentor. Furthermore, these resources also support employees with succession management potential to initiate a discussion with their line manager and/or mentor to determine their goals, strategies and direction for their succession management and career development trajectory (MNHHS, 2015a).

Employees with Succession Management Potential

Nursing/midwifery employees who are alerted to potential future opportunities within the workplace are more likely to stay with an organisation (Higginbottom, 2014). Therefore, it is important that all nursing/midwifery employees have access to succession management and career development opportunities regardless of their assessed potential (CHQHHS, 2015a). Career development and succession management potential needs to be discussed with individuals, however, potential succession management candidates also need to demonstrate an interest and desire to progress their own career (Trepanier & Crenshaw, 2013). When considering employees with succession management potential, their behaviours, attitudes, motivation and capability needs to be considered.

The PDP process should be used to identify potential succession management candidates and establish employee interest in succession management (CPS HR Consulting, 2017; Trepanier & Crenshaw, 2013) (refer to **Section 13, pages 60–62, of *The Framework***). During Phase 1, the PDP process should be used to assist line managers in supporting potential succession management candidates to identify their existing skills and those necessary for a classification or role. Additionally, this phase should establish and clarify role expectations, and promote nursing/midwifery CPD, succession management and career planning strategies (CPS HR Consulting, 2017; Queensland Health, 2018a) (refer to the **Standards for Succession Management, page 59, of *The Framework***). To assist with PDP expectations, the Career Pathways can provide direction and support nursing/midwifery employees to meet the standards of an aspiring classification and/or role (refer to **Section 8.2.1, pages 22–23, of *The Framework***).

It is important that employees are aware that succession management discussions imply no guarantee of appointment. Opportunities for career development rely on an individual's ability to demonstrate the key values and skill set/s required in accordance with the organisation and role requirements (MNHHS, 2015a). In addition, the nursing/midwifery workforce should be assessed for career development and succession management potential objectively by line managers, based on merit and independent of personal bias (CHQHHS, 2015a).

Employees Interested in Career Progression via Succession Management

The focus for career development should initially align to the Generic Level Statements for the relevant Award classification and role description (Nurses and Midwives [Queensland Health] Award – State 2015 [2018 Stage Wage Case Reprint], 2018). To further support the use of these resources, application of the Career Pathways can support individual nursing/midwifery employees to identify and acquire the requisite knowledge, skills, attributes and behaviours required to meet specific role expectations.

The Career Pathway Self-Assessment Activity provides nursing/midwifery employees with an opportunity to identify strengths and developmental needs in accordance with the generic domain considerations provided within the relevant Career Pathway for the aspiring classification and/or role (refer to **Section 8.2.1, pages 22–23, of *The Framework***). To support appropriate Career Pathway application, the nurse/midwife should refer to the relevant Career Pathway and associated activities for the aspiring classification and/or role. The Career Pathways have been developed for each classification (Grade 1 Band 1 – Grade 13 Band 2) to assist in the clear identification of role expectations and development activities. These resources can support and guide the establishment of an individually tailored program/plan for nursing/midwifery career development. Employees using the Career Pathways are also encouraged to refer to the AQF level/s to determine the nature and standard of postgraduate study that would assist in meeting the aspired role expectations (refer to **Appendix 3, page 75, of *The Framework***).

Additional responsibilities for nursing/midwifery employees who are interested in career progression include:

- establishing short- and long-term career goals
- keeping well-informed of potential succession management/career development opportunities
- proactively expressing interest in pursuing challenging new roles and responsibilities to their line manager
- taking risks to progress personal and professional development and their career pathway
- actively participating in the PDP process
- actively participating in supportive and developmental relationships (e.g. preceptorship, mentoring or coaching)
- accepting and acting on constructive feedback with regard to performance
- evaluating the success and value of succession management and career development opportunities (MNHHS, 2015a).

Nursing/midwifery employees with succession management potential and who are interested in career progression should be offered and supported to participate in CPD opportunities to facilitate an individually tailored succession management program/plan (refer to **Section 8, pages 17–19** and **Appendix 2, page 74, of *The Framework***).

Succession Management/Career Development Opportunities

Opportunities for succession management and career development will depend on the individual developmental needs of the nurse/midwife. A range of suggested career-broadening developmental experiences and activities targeted at personal and professional development have been provided within the Career Development Opportunities in the Workplace resource (refer to **Appendix 2, page 74, of *The Framework*** for additional examples of CPD activities). Nurses/midwives should engage in a discussion with their line manager to explore participating in the suggested career development opportunities within the workplace and use their PDP Agreement to document their interest and participation.

As discussed previously, it is also highly desirable that nurses/midwives explore an appropriate program of study at a relevant AQF level for the nursing/midwifery classification or role being fulfilled, or aspiring to fulfil (Queensland Health, 2018a) (refer to **Appendix 3, page 75–77, of *The Framework***).

6.4.2 Phase 2 – Development

Phase 2 focuses on the development of employees to enable the progression of their career through succession management strategies. As discussed in Phase 1, the PDP process must underpin succession management strategies (refer to **Standards for Succession Management, page 59, of *The Framework***). The PDP process provides employees with a valuable opportunity to discuss and plan their development with consideration of professional and organisational goals and future needs. The Succession Management and PDP Flowchart (Appendix 6) has been developed to identify the alignment of succession management principles with the PDP process, and the corresponding roles and responsibilities of the line manager and potential succession management candidate (MNHHS, 2015a). The Flowchart provided is an example and may be contextualised to align with established HHS/facility processes and available resources.

The line manager's responsibilities during the development phase include:

- ensuring a pool of talented, internal nursing/midwifery candidates are ready for development by identifying current and future needs of the HHS/facility through appropriate business planning and resource allocation review (Trepanier & Crenshaw, 2013).

- identifying nursing/midwifery employees with succession management potential and engaging in open, transparent and honest discussions about their career, succession management potential and any associated barriers
- maintaining awareness of the nursing/midwifery classifications and role expectations
- actively using, participating in and supporting the PDP process
- discussing succession management and career development opportunities with all nursing/midwifery employees, regardless of their perceived potential or interest (refer to **Section 13, page 60–62, of *The Framework***) (Trepanier & Crenshaw, 2013)
- identifying, facilitating and supporting relevant succession management and career development activities for nursing/midwifery employees (refer to Career Development Opportunities in the Workplace and **Appendix 2, page 74, of *The Framework*** for examples of CPD activities)
- providing coaching or supporting opportunities for developmental relationships (e.g. preceptorship or mentoring)
- maintaining transparency with nursing/midwifery employees by providing realistic expectations of potential roles and their associated responsibilities (CPS HR Consulting, 2017)
- impartially recruiting new nursing/midwifery employees based on merit selection
- undertaking ongoing assessment of nursing/midwifery succession management candidate performance
- evaluating the return on expectations and investment of implemented succession management strategies (MNHHS, 2015a)
- promoting the application of the Career Pathways (refer to **Section 8.2.1, pages 22–23, of *The Framework*)** and Orientation to Role Packages to assist nursing/midwifery employees in identifying the clinical, professional and organisational expectations and responsibilities of aspired nursing/midwifery roles
- promoting the application of Work Unit Development Maps to provide direction for CPD and lifelong learning complemented by milestone feedback (refer to **Section 10.3, pages 45–47, of *The Framework***) (Queensland Health, 2018a).

Individual learning pathways should be linked to a Work Unit Development Map to facilitate accelerated transition (refer to **Section 10.3, pages 45–47, of *The Framework***). Moreover, learning linked to a learning and/or career pathway supports employers/employees to engage in a comprehensive process of learning whereby strategies to reduce duplication and training variability are explored. The Nurse/Midwifery Educator is responsible for providing ongoing support and guidance to support the nurse/midwife in achieving the milestones and assessment criteria contained within the relevant Work Unit Development Map (refer to **Section 10.3, pages 45–47** and **Appendix 4, pages 78–84, of *The Framework*** for a comprehensive overview of Work Unit Developmental Maps and broad diagrammatic examples).

It is important that succession management strategies and outcomes are assessed periodically to determine current and future HHS/facility needs and priorities. Strategies should be flexible and able to be refined and adjusted to meet the changing needs of healthcare, the HHS/facility and the workforce (Deloitte, 2016).

6.4.3 Phase 3 – Outcomes

As stated in *The Framework*, "evaluation can be viewed as the process of appraising aspects of educational practices and activities for the purpose of demonstrating effectiveness and measuring and marketing performance" (Queensland Health, 2018a, p. 65) (refer to **Section 14.1, page 65, of *The Framework***). Regular evaluation of succession management strategies through defined key performance indicators (KPI) will demonstrate how effectively a HHS/facility is supporting and promoting succession management strategies and creating a culture of career development for the nursing/midwifery workforce. When succession management strategies are not reviewed regularly, goals may not be met and HHSs/facilities may not be fit to respond to unanticipated workforce changes (CQHHS, n.d.).

The following KPIs are a guide, and HHSs/facilities can contextualise them and consider the use of existing KPIs to evaluate the effectiveness of succession management strategies:

- Nursing/midwifery strategies and operational plans promote and support the implementation of succession management and career development activities and strategies.

- *The Framework*, Manual & Toolkit and associated resources (e.g. Career Pathways, Orientation to Role Packages and Work Unit Development Maps) are accessible to all nursing/midwifery employees.
- PDP feedback indicates that employees have an awareness of, and are able to use and apply, *The Framework*, Manual & Toolkit and associated resources appropriately and effectively.
- Position vacancies are advertised both internally and externally to the HHS/facility.
- EOIs are advertised for vacancies and distributed through the appropriate channels to maximise exposure to potential nursing/midwifery succession management candidates.
- A pool of nursing/midwifery employees with the appropriate skills, knowledge and attitudes are available to fulfil the responsibilities for each nursing/midwifery role and classification.
- Employees indicate that the HHS/facility's reputation for career development opportunities was a significant factor that influenced their decision to apply for a position and remain within the workplace/workforce/profession.
- Employees indicate satisfaction through the PDP process and identify that the support and development opportunities provided influenced their engagement, commitment and job performance.
- PDP feedback indicates that employees are negotiating career development/succession management goals, paths and activities and are participating in, and contributing to, the professional/career development and succession management of others (MNHHS, 2015a).

Succession management strategies and efforts are essential for the success and sustainability of a HHS/facility (CPS HR Consulting, 2017; Trepanier & Crenshaw, 2013). A proactive approach to succession management can support HHSs/facilities to develop a robust, confident and competent talent pool of nursing/midwifery employees who are prepared to fulfil the roles of the incumbent while facilitating smooth transitions when vacancies arise. Leadership stability, service excellence continuity and employee job satisfaction and retention may be compromised when a strategic approach to succession management is absent (Titzer et al., 2013). Nursing/midwifery leaders must acknowledge, appreciate and promote succession management strategies, such as mentoring, to foster capacity building and nursing/midwifery career development (Hodgson & Scanlan, 2013).

Mentoring is a valuable supportive relationship that can enrich succession management processes within an organisation (Moreno & Girard, 2019). Given mentoring is a recognised and supported succession management strategy to attract and retain nursing/midwifery employees, it is a process that should be established, maintained and supported within HHSs/facilities to promote the career development of the nursing/midwifery workforce and support capability and capacity building (Hodgson & Scanlan, 2013).

7. Mentoring

Mentoring is considered to be a symbiotic, dynamic and collaborative professional relationship whereby the mentor focuses on advancing the mentee's professional and personal goals, developing their leadership skills and supporting and promoting opportunities for growth (Smith, Hecker-Fernandes, Zoen, & Duffy, 2012; Zhang, Qian, Wu, Wen, & Zhang, 2016). It is a multifaceted process aimed at improving career satisfaction for both the mentor and mentee, which comprises different activities including supporting, teaching, encouraging, challenging, counselling, affirming, advising, protecting, advocating, sponsoring and evaluating (Lipscomb & An, 2013; McBride, Campbell, Woods, & Manson, 2017; Smith et al., 2012). A successful mentoring relationship involves commitment to personal and professional development from both parties. During the mentoring relationship, the mentor supports the mentee while producing an environment conducive to seamless development and transition (Zhang et al., 2016). It is a particularly important process for the mentee as it assists them to develop confidence, increased self-awareness and improved critical thinking and analysis abilities (Queensland Health, 2018a; Zhang et al., 2016). Throughout the relationship, the mentor "provides support, a sounding board, knowledge, encouragement, guidance, and constructive feedback to the mentee by developing a genuine interest in the growth of their abilities and talents" and the mentee "actively seeks support and guidance in their career and professional development from an experienced planner and has ultimate responsibility for their career and professional development" (Planning Institute Australia, n.d., p. 88).

Mentoring can be used for a variety of situations and at different points throughout a nurse/midwife's career, including (but not limited to):

- support of new starter nurses/midwives (in addition to other supportive and developmental relationships (refer to **Section 12, pages 49–59, of *The Framework***)
- nurses/midwives working towards promotion
- nurses/midwives who have changed roles within a HHS/facility
- changes to role or restructure
- CPD opportunity (Manchester Metropolitan University, n.d.).

It is important to note that no nursing/midwifery employee should consider themselves too senior to have a mentor or a trusted individual who they can consult regarding their career and professional practice (Dopson et al., 2017).

Effective succession planning and management should include mentoring as a proactive strategy to attract and retain employees and mitigate the consequences associated with nursing/midwifery intellectual capital attrition (Hodgson & Scanlan, 2013). Mentoring is an effective tool to assist employees to integrate within a HHS/facility, develop an understanding of the culture and politics and learn specific classification/role knowledge from mentors who are valued role models. Mentoring can be used as a stand-alone strategy or in conjunction with other supportive and developmental relationships (refer to **Section 12, pages 49–59, of *The Framework***) to support employees to develop personally and professionally within a nurturing learning environment (Titzer et al., 2013).

7.1 Related Supportive Developmental Relationships

As alluded to within *The Framework*, a commonality exists between preceptors, coaches and mentors as there is an interest to develop others (Queensland Health, 2018a) (refer to **Section 12, pages 49–59, of *The Framework***). As a result, there may be confusion regarding the nature, definitions and roles of these supportive and developmental relationships within healthcare (Nowell, Norris, Mrklas, & White, 2017). To facilitate shared understanding and relevant application of these supportive and developmental relationships, descriptors have been provided within the Glossary (Appendix 1) (refer to **Appendix 1, pages 69–74, of *The Framework***).

While the roles of a coach and mentor may overlap and complement each other within the workplace, there are differences between these supportive and developmental relationships (Dalgish, 2010; Hodgson & Scanlan, 2013; University of New South Wales [UNSW], 2015) (refer to **Section 12.2, pages 53–54 [coaching] and pages 55–57 [mentoring], of *The Framework***). The primary difference between coaching and mentoring is that coaching relates to a specific set of skills and expected outcomes, whereas mentoring is holistic and focuses on the development of the mentor throughout their career, or for an agreed period of time (UNSW, 2015).

Coaching is a collaborative, performance-based relationship whereby a coach is assigned to an employee to purposefully assist in the development of a specific skill/set of skills and maximise performance, learning and development. While coaches and mentors may use similar approaches, coaching tends to focus on technical skills or knowledge acquisition, in addition to the achievement of immediate goals (Morgan & Rochford, 2017). An effective coach supports the employee to identify and embrace ways to achieve their developmental needs (Bond University, 2018).

Although mentoring is likely to incorporate some of the strategies involved with coaching, it takes a broader approach to the growth and development of an employee through the transfer of skills, knowledge and attitudes over time. The mentoring relationship can be formed informally or formally through an established matching arrangement and different mentoring models can be applied to align with the mentee's needs and nature of the relationship (Morgan & Rochford, 2017).

7.2 Informal and Formal Mentoring Relationships

Successful mentoring relationships involve reciprocal participation in the mentoring process, whereby there is equal responsibility between the mentor and mentee for the outcomes of the relationship and each party recognises and takes advantage of the other's potential (Dopson et al., 2017; Nowell et al., 2017; Sunshine Coast Hospital and Health Service [SCHHS], n.d.-a; Zhang et al., 2016). The mentoring relationship is founded on intentional learning; however, the relationship can be informal or formal. The long-standing traditional method of mentoring has been informal (Valentin-Welch, 2016). Informal mentoring occurs when mentors and mentees agree to work together based on their common understanding, interests and goals (Hansman, 2016). Informal mentoring relationships seek to enhance self-esteem through the interpersonal dynamics of the relationship and the emotional bonds that are spontaneously established. Psychosocial supports that mentors provide during an informal mentoring relationship include role modelling, counselling and friendship (Hansman, 2016).

The characteristics of informal mentoring include:

- There is no formal link to strategic and/or organisational objectives.
- The mentor and mentee agree on specified goals and identify outcomes.
- Mentors and mentees select each other without the assistance of a Mentoring Coordinator/Champion/Delegate (if sponsored).
- The length of the mentoring relationship is influenced by the perception of mutual value and gain.
- The mentoring relationship is opportunistic and develops spontaneously. This relationship commonly evolves:
  - when one person takes an interest in the wellbeing and advancement of another
  - when initiative is taken by the mentee to approach a mentor and explain their intentions.
- No training or support is provided to the mentor by the HHS/facility or a Mentoring Coordinator/Champion/Delegate (if sponsored).
- Networking is promoted as the mentee needs to work to find the right mentor match.
- Mentees feel a sense of ownership and discretion.
- The mentor and mentee do not require/receive assistance from the HHS/facility or a Mentoring Coordinator/Champion/Delegate (if sponsored) and as a result:
  - mentees are unable to access information about mentors to assist with mentor matching
  - the mentoring relationship is not formally monitored or evaluated (Government of Western Australia – Department of Health, 2017; Management Mentors, 2018; Menges, 2016; MNHHS, 2015a; Valentin-Welch, 2016).

In contrast, formal mentoring is an established process that is facilitated through a HHS/facility/workplace program. To profit from the benefits of mentoring, formal mentoring programs have been initiated across a wide range of contexts, including healthcare (Menges, 2016). Formal mentoring seeks to accelerate the transfer of skills and knowledge that are relevant to an organisation from a mentor to a mentee, enhance workforce diversity and improve clinical, education, leadership, system support and research role skills and capability (Hansman, 2016). Furthermore, formal mentoring programs assist to preserve and promote positive workplace cultures, create candidates for potential vacancies in clinical, education, leadership, system support and research positions, reduce employee turnover and fulfil organisational diversity objectives (Hansman, 2016). It is important to understand the different

characteristics of informal and formal mentoring to appreciate their influence on mentees and the HHS/facility, in addition to their anticipated outcomes. It is acknowledged that a Mentoring Coordinator/Champion/Delegate may not be sponsored in all HHSs/facilities. Therefore, it is assumed that the mentee will select their own mentor with the support of their line manager.

The characteristics of formal mentoring include:

- There is a formal link to strategic and/or organisational objectives.
- It is a workforce development and planning strategy to promote capacity building and nursing/midwifery career development.
- The mentor and mentee agree on specified goals and identify measurable outcomes.
- The provision of matching criteria facilitates the strategic pairing of a mentor and mentee by a Mentoring Coordinator/Champion /Delegate (if sponsored).
- The length of the mentoring relationship is influenced by the perception of mutual value and gain.
- Training and support is provided to the mentor by the HHS/facility or a Mentoring Coordinator/ Champion/Delegate (if sponsored).
- Formal mentoring can serve as a mechanism to facilitate long-lasting mentoring relationships that become less formal over time.
- The mentoring relationship is monitored and evaluated by the HHS/facility or a Mentoring Coordinator/Champion/Delegate (if sponsored).
- Mentoring processes may feel rigid and regulatory.
- It requires time and investment by the Mentoring Coordinator/Champion/Delegate (if sponsored) (Management Mentors, 2018; Menges, 2016; MNHHS, 2015a; Queensland Health 2018a; SSSC, 2014).

As discussed, mentoring can be facilitated informally and organically whereby the mentee seeks out the mentor (or vice versa) or through a formal arrangement by a Mentoring Coordinator/ Champion/Delegate (if sponsored). The type of mentoring model used within practice is dependent upon the nature of the mentoring relationship and the individual needs of the mentee (Morgan & Rochford, 2017).

7.3 Mentoring Models

While mentoring arrangements have traditionally involved the partnership of two people, other models have developed over time that reflect the changing priorities and practices of the workforce and workplace (Nowell et al., 2017; SSSC, 2014). There are different types of mentoring processes used within healthcare that can evolve and be adapted to suit the context and circumstances of the mentor and mentee. Regardless of the model used, each model should have the mentee/s at the centre, with reflective practice as the foundation (SSSC, 2014). The mentorship models commonly used within the workplace include:

- **One-on-one mentorship model:** The mentee is matched with a mentor who will support their professional and personal development (Morgan & Rochford, 2017; SSSC, 2014).
- **Peer mentorship model:** Two or more employees with similar experience or rank interact as equal partners and mentors to achieve mutually determined goals (Morgan & Rochford, 2017; Nowell et al., 2017).
- **Group/team mentorship model:** One mentor supports a group of mentees who are collectively accountable to a common purpose of education and development (Nowell et al., 2017). This model can provide an opportunity for a mentor to work together with multiple peers on shared challenges and areas for development and growth. If there is a deficit of mentors within a HHS/facility, this model may be advantageous (SSSC, 2014).
- **Constellation mentorship model:** Multiple mentors have active interest and take action to progress an individual mentee's career (Nowell et al., 2017).
- **Distance mentoring/virtual mentoring/e-mentorship model:** Mentors and mentees communicate electronically (e.g. email, telephone, social media, text messaging or video conferencing) or through a mix of face-to-face and electronic communication methods (Government of Western Australia – Department of Health, 2017; Nowell et al., 2017; Valentin-Welch, 2016).
- **'Trans' mentorship model:** The mentor works outside of the mentee's context of practice. This model broadens the development of professional networking and fosters inter-departmental and disciplinary collaborations (Burgess, van Diggele, & Mellis, 2018).

- **Spot mentorship model:** A more casual approach is taken whereby a senior leader provides one-off mentoring 'spot meetings' to a mentee (Burgess et al., 2018).
- **Functional mentorship model:** A specific and structured mentoring relationship whereby the mentor assists a mentee to complete a particular task or assignment (e.g. a project) (Morgan & Rochford, 2017).
- **Reverse mentorship model:** The model involves reciprocal learning whereby older generations learn from the younger and vice versa. As a result, both parties act in the capacity of mentor and mentee. For example, a senior employee is mentored by a junior employee on topics such as technology or social media, and the junior employee is mentored by the senior employee based on their change management experience and skills (MNHHS, 2015a).
- **Cascading mentorship model:** Each level of a HHS/facility mentors the level/s below (MNHHS, 2015a).
- **Situational mentorship model:** The right help at the right time is provided by a mentor when a mentee requires guidance, assistance and support (MNHHS, 2015a).
- **Speed mentorship model:** Groups of mentors and mentees are brought together and the mentees rotate between each mentor every 10–15 minutes (Dopson et al., 2017).

Organisational responses to challenges such as capacity building, leadership development and quality improvement have led to the establishment of a range of creative mentoring approaches (SSSC, 2014). When mentoring models are established, maintained and supported to promote capacity building and nursing/midwifery career development, there are numerous advantages for the mentor, mentee and HHS/facility (Brody et al., 2016; Hodgson & Scanlan, 2013; Queensland Health, 2018a).

7.4 Advantages of Mentoring

There is a plethora of evidence regarding the advantages of mentoring within the literature (Brody et al., 2016; Hodgson & Scanlan, 2013; Titzer et al., 2013). Advocates of mentoring highlight that the benefits of the process are not only incurred by the mentee, but also the mentor and the HHS/facility (Fountain & Newcomer, 2016; UNSW, 2015).

7.4.1 Advantages for the Mentor

Mentoring can be advantageous for the mentor as it:

- provides an opportunity to:
  - actively assist in the professional development of an employee (UNSW, 2015)
  - develop awareness of personal behaviour
  - share experiences and knowledge
  - reflect on and articulate their role
  - test new ideas (Royal Children's Hospital [RCH], 2015)
- facilitates the development, or consolidation, of interpersonal skills such as counselling, listening, modelling and leading (RCH, 2015; UNSW, 2015)
- enhances self-esteem and confidence (DDHHS, 2018; Lavoie – Tremblay, Sanzone, Primeau, & Lavigne, 2019; UNSW, 2015)
- establishes insights into operations and culture within a HHS/facility (DDHHS, 2018; UNSW, 2015)
- may potentially renew enthusiasm and passion for the role (RCH, 2015)
- enhances recognition of skills and worth through encouragement to pursue a mentoring role (Gagliardi, Webster, Perrier, Bell, & Straus, 2014; RCH, 2015)
- improves job performance and satisfaction (Gagliardi et al., 2014; RCH, 2015).

7.4.2 Advantages for the Mentee

Mentoring can be advantageous for the mentee as it:

- improves knowledge, skills and abilities and facilitates the development of more advanced expertise (Smith et al., 2012; RCH, 2015)
- increases motivation and enthusiasm within the workplace (Lavoie – Tremblay et al., 2019)
- supports access to career development opportunities (Smith et al., 2012; UNSW, 2015)
- enhances competence (Zhang et al., 2016)
- reduces stress and anxiety within the workplace by easing transition and integration into the workforce (Cziraki, Read, Spence, Laschinger, & Wong, 2018; Gagliardi et al., 2014; Lavoie – Tremblay et al., 2019)
- enhances professionalism
- establishes a supportive environment (Zhang et

al., 2016)
- increases job satisfaction and retention (Brody et al., 2016; Gagliardi et al., 2014; Hodgson & Scanlan, 2013; UNSW, 2015)
- increases potential for career advancement.
- improves understanding of organisational roles and responsibilities
- develops appreciation for the complexities of decision-making within the organisation (RCH, 2015)
- improves morale (Chen, Watson, & Hilton, 2016; UNSW, 2015)
- supports problem-solving and critical thinking (Brody et al., 2016; UNSW, 2015; West et al., 2016)
- facilitates the development of new skills, (e.g. conflict resolution) (UNSW, 2015)
- encourages the exploration of different perspectives and attitudes
- enables improved understanding of HHS/facility culture, values and norms
- supports the evaluation of successes and failures in a non-confrontational way (RCH, 2015)
- facilitates access to new professional networks and contacts (DDHHS, 2018; UNSW, 2015).

7.4.3 Advantages for the HHS/Facility

Mentoring can be advantageous for the HHS/facility as it:

- develops potential in emerging and current leaders (UNSW, 2015)
- supports the retention of talented employees (Fountain & Newcomer, 2016; Marsh, 2015; UNSW, 2015; Valentin-Welch, 2016)
- increases employee job satisfaction and productivity due to enhanced motivation (UNSW, 2015)
- assists to identify and develop the next generation of employees capable of fulfilling clinical, education, leadership, system support and research roles and responsibilities (Dopson et al., 2017)
- improves employee relationships and a culture of collaboration (Hafsteinsdottir, van der Zwagg & Schuurmans, 2017; UNSW, 2015)
- enhances community, collegiality and improved communication between different areas within the HHS/facility (Fountain & Newcomer, 2016; RCH, 2015; UNSW, 2015)
- improves service delivery by supporting employees to be more prepared, informed and competent
- reduces recruitment expenditure due to the potential for increased internal recruitment and employee retention
- provides a support network for employees during times of HHS/facility change or turbulence
- increases the number of mentors within the HHS/facility as most successful mentees will become mentors
- increases the number of committed, engaged and productive employees who can support succession planning and management strategies
- supports the transfer of HHS/facility values and norms (RCH, 2015).

The development of effective mentoring relationships and achievement of mentoring benefits remain a challenge within healthcare (Leary, Schainker, & Leyenaar, 2016). The barriers to mentorship must be identified by HHSs/facilities to support the design, implementation and evaluation of effective mentorship programs (White, Nowell, Benzies, & Rosenau, 2017).

7.5 Barriers to Mentoring Success

It is important for HHSs/facilities to be aware of potential barriers and obstacles that may challenge the implementation of effective mentoring programs (Zhang et al., 2016). Barriers to mentoring may include:

- a poor mentoring culture within a HHS/facility, potentially exacerbated by lack of support and encouragement by the executive team (Association of Queensland Nursing and Midwifery Leaders [AQNML], 2013; Gagliardi et al., 2014; Government of Western Australia – Department of Health, 2017; Ramseur, Fuchs, Edwards, & Humphreys, 2018)
- mentoring is viewed as a low priority strategy (Hafsteinsdottir et al., 2017)
- potential mentors, or current mentors, do not have access to *The Framework*, Manual & Toolkit and associated resources (e.g. Career Pathways and Orientation to Role Packages) to support their role and responsibilities
- there is no supported or sponsored Mentoring Coordinator/Champion/Delegate, and as a result, mentors may not be adequately prepared for or supported in their role

- there is a failure to reward mentoring, which may restrict sustainability (Smith et al., 2012)
- mentoring is perceived as an extra burden of responsibility and an emotionally draining or stressful experience (Government of Western Australia – Department of Health, 2017)
- there is a limited pool of mentors in a HHS/facility (White et al., 2017)
- roles, responsibilities and expectations of the mentor, mentee, line manager and Mentoring Coordinator/Champion/Delegate (if sponsored) are not adequately defined and understood in a HHS/facility (Government of Western Australia – Department of Health, 2017).

7.6 Roles, Responsibilities and Expectations

It is important that there is mutual investment and accountability from the mentor, mentee, line manager and Mentoring Coordinator/Champion/Delegate (if sponsored) to support the development and sustainability of successful mentoring relationships and enable all parties to benefit from the recognised advantages (CHQHHS, 2015b). The roles, responsibilities and expectations of the mentor, mentee, line manager and Mentoring Coordinator/Champion/Delegate (if sponsored) have been further defined.

7.6.1 Roles, Responsibilities and Expectations of the Mentor

The roles, responsibilities and expectations of the mentor can be divided into three (3) sections:

Role Model Excellence and Standards in Practice

- attending a Mentoring Training Workshop (if sponsored within a HHS/facility)
- demonstrating commitment to the nursing/midwifery profession
- demonstrating knowledge, competence and confidence within their context of practice
- acting as a role model and displaying positive behaviour in accordance with organisational and professional Standards, Codes and Guidelines (Gold Coast Hospital and Health Service [GCHHS], 2018b)
- being non-judgemental and accepting differences in people and their styles of working (UNSW, 2015)
- being committed to assisting mentees achieve their goals and reach their full potential (SCHHS, n.d.-b; UNSW, 2015)
- collaborating with a diverse network of contacts within the wider healthcare system
- expanding knowledge and expertise using evidence-informed research
- remaining aware of contemporary trends, issues and practices relevant to the nursing/midwifery profession (MNHHS, 2015a).

Develop an Effective Supportive Relationship

- Creating a climate of trust (RCH, 2015)
- Attending all scheduled meetings and being prepared and actively participating in the mentoring relationship (CHQHHS, 2015b; DDHHS, 2018; SCHHS, n.d.)
- Facilitating the transfer of knowledge (Sibbald et al., 2017)
- Acting as a supportive and facilitative adviser (Zhang et al., 2016)
- Participating in ongoing reflection on what has been shared and learned
- Maintaining confidentiality (UNSW, 2015)
- Disclosing relevant and appropriate work and life experiences to the mentee to personalise the relationship (RCH, 2015)
- Being approachable and creating a positive, supportive relationship
- Demonstrating care for the wellbeing of mentees
- Acting as a soundboard and listening to the mentee's needs, issues, concerns, expectations and goals
- Providing a safe relationship by nurturing, supporting and encouraging mentees
- Praising achievements and successes with mentees
- Collaborating and negotiating the aim, aspirations, processes, boundaries and evaluation processes of the mentoring relationship with the mentee
- Respecting the mentee's right to make decisions, but intervening when ethically appropriate (MNHHS, 2015a)
- Addressing any potential or actual misunderstandings of the role and responsibilities of the mentor, mentee and line manager (MNHHS, 2015a; Nova Scotia Public Service Commission, 2015).

Foster Mentee Growth

- Supporting mentees to identify achievable and appropriate goals (DDHHS, 2018)
- Using knowledge, skills and abilities to assist and guide mentees with career planning
- Guiding mentees to identify activities and realistic timeframes for goal achievement
- Assisting mentees to identify, define and manage barriers, issues and concerns
- Encouraging, challenging and supporting mentees to take on challenges and step out of their comfort zone (Hodgson & Scanlan, 2013; UNSW, 2015)
- Supporting mentees to develop effective negotiation and conflict resolution abilities
- Sharing professional networks, informal rules and unspoken knowledge (SCHHS, n.d.-b)
- Introducing the mentee to new networks and contacts and encouraging the mentee to network with individuals who may be supportive and helpful (UNSW, 2015)
- Promoting and advocating for the mentee and their achievements (MNHHS, 2015a)
- Identifying and making the most of 'teachable' moments (Sibbald et al., 2017; UNSW, 2015)
- Guiding mentees to identify and explore their views, interests and beliefs while considering alternatives (RCH, 2015)
- Believing in the mentee's capability (Hodgson & Scanlan, 2013)
- Acting as a great listener and providing advice (UNSW, 2015)
- Providing timely, accurate, objective, challenging and supportive feedback (DDHHS, 2018; UNSW, 2015)
- Challenging mentee explanations and ideas and offering insights regarding the need to re-evaluate beliefs, assumptions or practices
- Being prepared to have personal beliefs and values challenged (RCH, 2015)
- Encouraging and promoting independence and autonomy, when appropriate (UNSW, 2015)
- Stimulating mentees to critically think about their strengths, gaps, goals and their future (RCH, 2015)
- Willing and able to share their knowledge, experience, resources and networking contacts with the mentee to support the achievement of their goals (GCHHS, 2018b)
- Reflecting on and discussing lessons learned with mentees
- Encouraging the mentee to be the driver of the mentoring relationship
- Communicating perceptions and insights relating to decision making, conflict resolution and future planning in a constructive and sensitive manner (GCHHS, 2018b)
- Participating in the evaluation and review process of the mentoring relationship (CHQHHS, 2015b; DDHHS, 2018).

7.6.2 Roles, Responsibilities and Expectations of the Mentee

The roles, responsibilities and expectations of the mentee include:

- initiating contact with their mentor on a regular basis (CHQHHS, 2015b; DDHHS, 2018)
- committing to regular communication and discussing issues and concerns openly (GCHHS, 2018b)
- attending all scheduled meetings, being prepared and actively participating
- implementing agreed tasks within prescribed time frames (CHQHHS, 2015b)
- willing to learn and take on new challenges (Hodgson & Scanlan, 2013; UNSW, 2015)
- determining the overall agenda of the mentoring relationship
- being an open and honest communicator to develop a trusting and collegial relationship with the mentor
- participating in self-assessment and reflection to identify personal strengths, weaknesses, developmental needs and succession management potential (if relevant)
- providing timely, accurate and objective feedback to the mentor on their ability and approach (SCHHS, n.d.-b)
- being respectful of the mentor's time and efforts (MNHHS, 2015a)
- being committed to personal and professional growth and the expansion of skills, competence and confidence
- acting as the proactive partner and taking initiative in monitoring learning needs and career goals (Hodgson & Scanlan, 2013; SCHHS, n.d.-b)
- negotiating and establishing priority issues or concerns for escalation and support
- communicating learning needs and being committed to addressing barriers to success (CHQHHS, 2015b)

- acting as a great listener
- maintaining confidentiality
- seeking and accepting positive and negative feedback UNSW, 2015)
- appreciating different perspectives and the exploration of other options/opinions (CHQHHS, 2015b)
- participating in ongoing reflection on what has been shared and learned during the mentoring relationship (UNSW, 2015)
- setting attainable goals and proactively working towards achieving them (DDHHS, 2018; Lipscomb & An, 2013; UNSW, 2015)
- being prepared to have personal beliefs and values challenged (RCH, 2015)
- participating in the evaluation and review process of the mentoring relationship (CHQHHS, 2015b; DDHHS, 2018)
- addressing any potential or actual misunderstandings of the role and responsibilities of the mentor, mentee and line manager (MNHHS, 2015a; Nova Scotia Public Service Commission, 2015).

7.6.3 Roles, Responsibilities and Expectations of the Line Manager

While it is recommended that a line manager is not involved in a mentoring relationship with employees who report directly to them, they have an important role in supporting, promoting and engaging in the mentoring process. It is advised that line managers who plan to mentor employees with whom they have a direct reporting line consider the potential risks and pitfalls associated with this dual role, given the separation of managerial tasks (e.g. performance review and assessment) from the model of mentoring may present as a challenge (SSSC, 2014).

To support mentoring, the roles and responsibilities of the line manager include:

- setting work goals and targets with the employee/mentee
- supporting and facilitating the employee's development
- becoming a mentor or supporting other relevant individuals to be mentors
- promoting mentorship and facilitating access to supporting documents and resources, including *The Framework* and the Manual & Toolkit
- assisting in matching mentors and mentees if no sponsored Mentoring Coordinator/Champion/Delegate exists within a HHS/facility
- supporting the development and documentation of mentoring relationships
- facilitating opportunities for the mentor and mentee to participate in mentoring discussions
- providing resources and opportunities for the mentor and/or mentee to participate in developmental activities
- reviewing and appraising performance and providing timely, accurate and objective feedback
- providing feedback to the mentee and mentor (if appropriate) around the changes they have observed in the mentee and their performance
- evaluating the application of mentoring guidelines, strategies and toolkit resources in the workplace
- addressing any potential or actual misunderstandings of the role and responsibilities of the mentor, mentee and line manager (MNHHS, 2015a; Nova Scotia Public Service Commission, 2015).

7.6.4 Roles, Responsibilities and Expectations of the Mentoring Coordinator/Champion/Delegate (if sponsored)

A formal mentoring program within a HHS/facility will be dependent upon local support, context, culture and purpose (SSSC, 2014). The roles, responsibilities and expectations of the Mentoring Coordinator/Champion/Delegate (if sponsored) include:

- promoting mentoring and increasing engagement with the process by facilitating access to supporting documents and resources, including *The Framework* and the Manual & Toolkit
- guiding the delivery of a mentoring program by:
  - developing and providing training workshops for mentors (Planning Institute Australia, n.d.)
  - supporting the development and tracking of trained and prepared mentors
  - evaluating and reporting on training and program effectiveness (MNHHS, 2015a; SSSC, 2014)
- supporting mentor-mentee dyads when difficulties and/or conflict are experienced
- monitoring current mentoring relationships
- supporting the induction of mentees

- recruiting and selecting mentors and mentees
- facilitating mentor/mentee matching.

The mentor, mentee, line manager and Mentoring Coordinator/Champion/Delegate (if sponsored) all have a vital role to play in the mentoring journey. When all parties collaborate to achieve an effective and structured approach to mentoring within a HHS/facility, a culture of lifelong learning is promoted and supported. Mentoring provides nursing/midwifery employees with a valuable opportunity to establish goals and clear professional development and career pathways, ultimately contributing to the development of a talented and competent nursing/midwifery workforce (CHQHHS, 2015b).

7.7 The Mentoring Journey

Throughout the multifaceted mentoring journey, the relationship between the mentor and mentee evolve through several phases, including recognition and development, enabling and emerging independence and the conclusion of the formal relationship (MNHHS, 2015a). The mentoring relationship should be continually evaluated to monitor and evaluate the mentee's progress towards the achievement of developmental goals. Accordingly, the PDP process underpins mentoring by providing nurses/midwives and their line managers with a valuable opportunity to discuss and devise a plan for an employee's development at regular intervals (refer to **Section 13.1, pages 60–62, of *The Framework***).

The Standards for Mentoring (Appendix 2) within *The Framework* (refer to **Section 12.5, page 56, of *The Framework***) indicate that mentoring should be established, maintained and supported to promote capacity building and nurse/midwife career development as per HHS/facility processes (Queensland Health, 2018a). Further, nursing/midwifery governance determines a means for matching mentors and mentees as per specific HHS/facility processes and the development and tracking of a pool of appropriately trained and prepared mentors. Therefore, the following sections will refer primarily to formal mentoring processes and include the following considerations:

- mentor and mentee recruitment, selection and preparation
- mentor and mentee matching
- initial mentoring meeting
- subsequent mentoring meetings
- giving and receiving feedback
- evaluation of mentoring relationship.

The Mentoring Process Flowchart (Appendix 7) provides a diagrammatic representation of the mentoring journey comprising the three phases. The Flowchart has been developed as an exemplar to identify the anticipated mentor and mentee functions throughout each phase of the mentoring relationship (MNHHS, 2015a). If applied, the Flowchart should be adapted to align with established HHS/facility processes and available resources. Moreover, the processes contained within the Mentoring Process Flowchart should be contextualised to a nurse/midwife's individual development pathway.

7.7.1 Phase 1 – Recognition and Development

Phase 1 involves the mentee recognising the need for mentoring, selecting or confirming nominated mentor and participating in the initial mentoring meeting whereby the mentor and mentee can establish their relationship (MNHHS, 2015a).

Mentor Recruitment, Selection and Preparation

It is important that current or aspiring mentors demonstrate the appropriate characteristics, abilities and attitudes that are required to facilitate the personal and professional development of their mentee and support the growth of a successful mentoring relationship (AQNML, 2013). Appendix 8 identifies the essential characteristics, abilities and attitudes of a mentor.

The following factors need to be considered when determining mentor eligibility:

- equal or greater experience than the mentee (the reverse mentorship model is an exception)
- comprehensive knowledge of the HHS/facility and the associated goals, policies, procedures, functions, communication channels and education programs
- awareness of available internal and external resources that can support the mentoring relationship
- flexible and open-minded leadership style
- compatible personality style with potential mentee
- prepared to maintain contact with the mentor and allocate time to follow through with meeting tasks and activities
- prepared to allow mentees to assume

responsibility and accountability for their personal and professional development
- committed to the personal and professional development of others
- committed to maintaining confidentiality
- prepared to contribute to evaluation processes of the mentoring relationship (MNHHS, 2015a; SSSC, 2014).

Employees who are interested in being a mentor are encouraged to:

1. Discuss their interest and intent in providing mentorship with their line manager and include this within their PDP (refer to **Section 13.1, pages 60–62, of *The Framework***).
2. Assess their capacity and availability to provide mentorship.
3. Attend a Mentoring Training Workshop (if sponsored).
4. Complete the Mentor Expression of Interest and send to the Mentoring Coordinator/ Champion/Delegate within the HHS/facility (if sponsored).
5. Complete the Mentor Initial Self-Reflection prior to the initial mentoring meeting to explore their individual needs, interests, concerns and expectations regarding the mentoring relationship.
6. Participate in relevant training and professional development opportunities to maintain their breadth of knowledge and expertise.

Mentee Recruitment, Selection and Preparation

A mentee is an individual who is seeking to gain knowledge and skills through the development of a mentoring relationship with a nursing/midwifery role model. A mentee needs to be willing and able to participate in the mentoring relationship and be committed to its growth and potential (AQNML, 2013). Appendix 8 identifies the essential characteristics, abilities and attitudes of a mentee.

The following factors need to be considered when determining mentee eligibility:

- committed to, and assumes responsibility for, personal and professional development
- prepared to learn
- receptive to feedback
- prepared to trust the mentor
- committed to maintaining confidentiality
- prepared to maintain contact with the mentor and allocate time to follow through with meeting tasks and activities (MNHHS, 2015a; SSSC, 2014).

Employees who are interested in participating in mentorship are encouraged to:

1. Discuss with their line manager their interest and intent in participating in a mentoring relationship and incorporate within their PDP Agreement (refer to **Section 13.1, pages 60–62, of *The Framework***).
2. Assess their capacity and availability to participate in a mentorship relationship.
3. Complete the Mentee Expression of Interest and send to the Mentoring Coordinator/ Champion/Delegate within the HHS/facility (if sponsored).
4. Complete the Mentee Initial Self Reflection to explore individual needs, interests, concerns and expectations to assist in forming the basis and structure of the mentoring relationship.
5. Select/confirm preferred mentor from suggested list provided by Mentoring Coordinator/Champion/Delegate (if sponsored).
6. Contact the nominated or self-selected mentor to arrange an initial meeting (MNHHS, 2015a).

Mentor and Mentee Match

Mentor and mentee matching plays a pivotal role in the success of a mentoring relationship (Tiew, Koh, Creedy, & Tam, 2017; Zhang et al., 2016). Mentors may be allocated/formally matched by a Mentoring Coordinator/Champion/ Delegate (if sponsored) through the information provided in the expression of interest, or selected by the mentee (Cummins, Denney-Wilson, & Homer, 2017). Personality type, values, interests and specific mentee requirements need to be considered when matching a mentor and mentee (Burgess et al., 2018; Zhang et al., 2016). Mentors who are appropriately matched to a mentee will assist in reducing stress and improving job satisfaction (Tiew et al., 2017). Networking opportunities and including the mentor and mentee in the matching process is encouraged (Nowell et al., 2017).

Given each individual has a different style, in addition to values, beliefs and attitudes, mentors

and mentees should not be disappointed when a mentoring relationship is not productive and successful. It is important to find a mentor that complements the mentee, and vice versa, and this process can take time to find the perfect fit (GCHHS, 2018b).

Initial Mentoring Meeting

The initial responsibility of the mentor and mentee once a mentoring relationship has been formed is to establish whether their selected mentor/mentee is appropriate for them and that their qualities and values are conducive to a positive and fruitful relationship. During the initial meeting, both parties should get to know each other, share information about their background and career trajectory and establish trust. Developing rapport is a vital component, which will contribute to a successful mentoring relationship (Lipscomb & An, 2013).

While an effective mentor is fundamental to the success of a mentee, the mentoring relationship needs to be evolutionary and collaborative, not static and didactic (DDHHS, 2018).

Initially, the mentor may need to lead the meetings. However, as the mentee develops confidence and independence, they should be encouraged to be responsible and accountable for their personal and professional development and guiding the direction of subsequent meetings (SSSC, 2014).

During the initial meeting, the mentor and mentee are encouraged to negotiate and develop the Mentor and Mentee Partnership Agreement to establish the goals, expectations and ground rules for the mentoring relationship. Furthermore, if the mentee engages in mentorship as a succession management strategy, the mentee is encouraged to complete the Career Pathway Self-Assessment Activity. The Career Pathway Self-Assessment Activity provides nursing/midwifery employees with an opportunity to identify strengths and developmental needs in accordance with the generic domain considerations provided within the Career Pathway for the aspiring classification and/or role (refer to **Section 8.2.1, pages 22–23, of *The Framework***). To support appropriate Career Pathway application, the nurse/midwife should refer to the associated developmental activities for the aspiring role. The Career Pathways have been developed for each classification (Grade 1 Band 1 – Grade 13 Band 2) to assist in the clear identification of role expectations. These resources can support and guide the establishment of an individually tailored program/plan for nursing/midwifery career development.

Suggestions for planning and managing the first mentoring meeting include:

1. Define roles.
2. Clarify expectations, opportunities, priorities and goals.
3. Identify resource requirements.
4. Agree on meeting format, timing and location.
5. Discuss and confirm realistic timeframes for goal achievement.
6. Discuss the estimated duration of the mentoring relationship.
7. Discuss and create opportunities for mentee growth.
8. Schedule the next meeting (CHQHHS, 2015b; Manchester Metropolitan University, n.d.; Planning Institute Australia, n.d.; SSSC, 2014).

The outcome of Phase 1 may be progression to Phase 2, or the relationship may end by mutual agreement if the relationship is not conducive to growth and development and/or the mentor and mentee cannot commit to the mentoring relationship (MNHHS, 2015a).

7.7.2 Phase 2 – Enabling and Emerging Independence

During Phase 2, the mentor and mentee focus on developing a supportive and open relationship, implementing strategies to facilitate the achievement of agreed goals, objectives and expectations and providing reciprocal constructive, timely and objective feedback to support self-reflection (MNHHS, 2015a).

Subsequent Mentoring Meetings

Subsequent and ongoing mentoring meetings seek to foster and develop a supportive and trustworthy mentoring relationship. This can be facilitated by learning about each other's interests and opinions. Mentors and mentees should also share some of their personal career and important life experiences. Similarly, a discussion on what is important and what drives each individual personally and professionally will support the development of an open and honest relationship (planning Institute Australia, n.d.). During these meetings, the mentor and mentee should also revisit goals and identify achievements, discuss actions, strategies and evaluate outcomes regularly (SSSC, 2014).

Mentors need to be mindful and not dominate the conversation, exert undue influence or disregard alternative opinions during meetings. The mentor's role is to support and facilitate mentee growth by encouraging them to take responsibility for their critical thinking and problem solving. The mentor should assist the mentee to work through their issues and support them to see the broader view before presenting an alternative viewpoint or argument (Planning Institute Australia, n.d.). During a conversation, a mentor should act as a sounding board, impart their wisdom, and allow the mentee to make decisions (GCHHS, 2018b). The Mentor Conversation Starter Guide can be used to support meaningful conversations between the mentor and mentee during regular meetings.

During subsequent meetings, mentors and mentees are encouraged to complete the Meeting Journal Sheet to support the recordkeeping of meeting discussion points and actions. Meeting logs assist to create a focus and structure for meetings, record the progress of the mentoring relationship and provide data for evaluation and/or auditing purposes (SSSC, 2014). Furthermore, the mentor and mentee are individually encouraged to complete the Reflective Journal Sheet to support and facilitate the lifelong learning, critical thinking and self-reflection (DDHHS, 2018).

Suggestions for planning and managing subsequent and ongoing mentoring meetings include:

1. Review the notes and action items from the previous meeting.
2. Discuss and celebrate successes.
3. Discuss and critique challenges.
4. Continue to review and revisit the initial goals established at the commencement of the mentoring relationship.
5. Discuss, summarise and record the main themes from each meeting.
6. Identify agenda items for the next meeting.
7. Schedule the next meeting (SSSC, 2014).

Feedback and Reflective Practice

Feedback is an essential component of the mentoring relationship and facilitates personal learning and professional development (Sinclair et al., 2015). The mentee requires constructive feedback to develop as an independent and confident clinician (Vinales, 2015). When feedback is absent, or the mentor denies the mentee honest feedback, mentees are left to 'fill in the blanks' on their performance and development (Government of Western Australia – Department of Health, 2017; University of Washington, n.d.). When feedback is provided, it enables the mentee to understand their developmental learning needs, strengths and weaknesses. Entering a dialogue with the mentee can prove beneficial when providing feedback as the mentor and mentee can be partners in the process (Sinclair et al., 2015). The Mentor Conversation Starter Guide provides various questions and statements to assist the mentor in assessing mentee understanding and their willingness to listen (DDHHS, 2018; GCHHS, 2018b; University of Washington, n.d.). Moreover, the mentor can use the questions and statements to encourage mentee self-assessment and reflective practice (University of Washington, n.d.).

Throughout the mentoring relationship, the role of the mentor is to provide support and feedback, with the purpose to stimulate the mentee to engage in reflective practice (Tonna, Bjerkholt, & Holland, 2017) (refer to **Section 12.4, pages 55–57, of *The Framework***). A mentor who provides resources, encouragement and guidance to promote reflective practice by the mentee challenges their thinking and supports them to view things from a different perspective (Queensland Health, 2018a). The provision of feedback by the mentee on the mentor's ability to support them in the relationship is also equally important (Government of Western Australia – Department of Health, 2017).

7.7.3 Phase 3 – Conclusion of Formal Relationship

In an ideal situation, the mentoring relationship concludes once there is no further need or use for the process as agreed by both parties. At this point in time, the mentee may have become self-reliant and confident and be meeting the goals of the mentoring relationship, or the mentoring relationship may be coming to a close as per the agreed end date (if applicable) (Burgess et al., 2018; Manchester Metropolitan University, n.d.). However, there are various other reasons that may cause a mentoring relationship to end. Some examples have been provided in the 'Managing an Ineffective Mentoring Relationship' section. If the mentoring relationship ends prematurely without appropriate closure, detrimental feelings such as abandonment and resentment may be experienced by the mentor or mentee (Burgess et al., 2018).

To support the appropriate closure of a mentoring relationship, it is important for the mentor and

mentee to revisit the original goals and objectives and compare them to the actual outcomes achieved (Manchester Metropolitan University, n.d.). Furthermore, the mentor and mentee should reflect on the positive and negative aspects of the relationship, acknowledge and celebrate achievements and support the application of lessons learned to practice and future mentoring relationships (DDHHS, 2018). It is also important to note that a mentor and mentee may wish to continue meeting in a different capacity once the mentoring relationship has ended (SCHHS, 2018).

Evaluation of Mentoring Relationship

Evaluation of a mentoring program and associated strategies (if sponsored) can assist HHSs/facilities to make necessary adjustments and determine return on expectations and investment. It is an important process that involves appraising components of educational practices and activities to demonstrate effectiveness, and measure and market performance (Queensland Health, 2018a) (refer to **Section 14.1, pages 65–67, of *The Framework***).

The mentoring process should be continually evaluated throughout the duration of the relationship and at the completion of the process. Evaluation is achieved by identifying whether established goals are being met and by documenting outcomes and successes as they are achieved (AQNML, 2013). Similarly, the PDP process should be used to monitor and evaluate the progress of the mentee in achieving their established career and developmental goals and the mentor in developing personally and professionally as a supportive resource person and/or achieving succession management/career development goals (refer to **Section 13.2, pages 60–62, of *The Framework***) (MNHHS, 2015a).

To support and facilitate the identification of mentor/mentee strengths and areas for improvement, each party is encouraged to complete the respective Mentor Evaluation Tool and Mentee Evaluation Tool periodically at agreed intervals (e.g. 3, 6, 9 and 12 months) and at the conclusion of the mentoring relationship. The evaluation tools should be filed in the individual's PDP file and provided to the Mentoring Coordinator/Champion/Delegate (if sponsored).

If a mentoring training workshop is supported within a HHS/facility, further evaluation of program effectiveness and performance can be conducted through the collation of data from:

- number of mentor and mentee EOIs
- mentor recruitment
- mentor training workshop attendance
- mentor training workshop participant evaluations
- mentor and mentee matching success
- mentor and mentee evaluation tools.

Evaluation of mentoring within a HHS/facility will vary depending on the size, extent of program use and the support and availability of a Mentoring Coordinator/Champion/Delegate (MNHHS, 2015a).

7.8 Managing an Ineffective Mentoring Relationship

While the benefits of mentoring outweigh the risks, not all mentoring relationships are effective and successful (Burgess et al., 2018). There are a variety of factors, including some ethical issues, which may cause a mentoring relationship to be unsuccessful or ineffective, such as:

- the mentor is new to the role or inadequately prepared (Smith et al., 2012)
- involuntary participation by mentor or mentee (Stewart-Lord, Bailie, & Woods, 2017)
- the mentee/mentor match is poorly constructed and the relationship feels forced and/or unnatural (Smith et al., 2012)
- a purpose for the mentoring relationship has not been clearly defined
- lack of individual or dual commitment to the mentoring relationship resulting in disengagement
- there is a lack of time and availability by individual or both parties to pursue the mentoring relationship, including scheduling limitations (Haftsteinsdottir et al., 2017; Zhang et al., 2016)
- meetings are unstructured
- goals are not set through collaboration with the mentee
- manipulative behaviour is present (Lunsford, 2016)
- there is no preparation for closure or ending of the mentoring relationship
- there is role blurring (e.g. a line manager acts as a mentor for their employee)
- failure to review progress and the effectiveness of the mentoring relationship at regular intervals
- there is a conflict of interest
- the mentee is feeling judged/assessed (MNHHS, 2015a)

- the mentee is feeling vulnerable, unsafe or insecure and is fearful of asking questions or engaging with the mentor
- the process is used as a social interaction opportunity (MNHHS, 2015a)
- there are personality/value/belief/cultural clashes or differences that are incompatible with an appropriate mentor/mentee match (Gagliardi et al., 2014; Government of Western Australia – Department of Health, 2017)
- perceived or real competition exists between the mentor and mentee
- the mentee is dependent on the mentor
- confidentiality is not maintained
- a power imbalance exists
- unrealistic/false/unequal expectations of the mentor or mentee are set (Burgess et al., 2018; SSSC, 2014; Smith et al., 2012).

While it is understood that differences and conflicts may arise with any supportive and developmental relationship, it is important to manage these difficulties to preserve the intent of the relationship. Strategies to manage an ineffective and/or unsuccessful mentoring relationship may include:

1. Identify the issue/s that is causing the mentoring relationship to be ineffective/ unsuccessful.

- Maintain accurate and thorough documentation throughout the mentoring relationship, including the Meeting Journal Sheet, Reflective Journal Sheet and Evaluation Tool.
- Profile forms and file notes can be used to record progressive entries when conflict and/or friction may be present.
- Establish the underlying issue/s that may be causing the mentoring relationship to be ineffective/unsuccessful (e.g. mentor fatigue, increased workload, inadequate preparation etc.) (MNHHS, 2015a).

2. Facilitate open and honest communication between the mentor and mentee.

- The mentor and mentee should talk openly with each other about the issue/s and actively listen to what each person has to say without blame. Preferably, this dialogue should take place in person. Strategies and solutions to resolve the issue/s should be openly and mutually explored.

3. Engage a support network.

- Discuss the issue/s with an independent person, such as a line manager, to assist in broadening perspective and reframing the issue/s.
- Appoint a mediator if required. The mediator should be an objective, neutral third party whose judgement is respected by the mentor and mentee (University of Illinois at Chicago, n.d.).

4. Explore modifications to the mentoring relationship.

- Collaboratively review the Mentor and Mentee Partnership Agreement and negotiate feasible and realistic changes to the mentoring relationship if it is salvageable.

5. Consider alternatives to the present mentoring relationship.

- If the mentor and mentee identify that there is a mismatch or issue/s that are unable to be resolved and both agree that a switch is desirable, this should be discussed with the Mentoring Coordinator/Champion/Delegate (if sponsored) or the respective line manager (University of Illinois at Chicago, n.d.).
- The mentor and mentee may agree to conclude the relationship if it is no longer conducive to supportive and professional career development (MNHHS, 2015a).

Mentoring is considered to be an invaluable strategy to develop the current and future nursing/midwifery workforce and should be regarded as an effective means to promote and support the development of the profession (Queensland Health, 2018a). A successful mentoring relationship promotes professional development, encourages interprofessional collaboration and has a positive impact on employee job satisfaction, work performance and engagement. Hence, mentoring should be a crucial component of any HHS/facility's workforce development plan or strategy (Burgess et al., 2018; Sinclair et al., 2015). With the ageing workforce and anticipated nursing/midwifery shortage, mentoring must also be recognised and supported by HHSs/facilities as an essential succession management strategy that may contribute to career satisfaction and assist in retaining and attracting nursing/midwifery succession management candidates (Hodgson & Scanlan, 2013; Mariani, 2012).

Succession Management & Mentoring Toolkit

The *Succession Management & Mentoring Toolkit* comprises a set of resources that can be used to support the effective application of succession management, career development and mentoring strategies for nurses/midwives working within Queensland Health (Collins English Dictionary, 2018; MNHHS, 2015b). The resources are designed to be applied and implemented after users have read the initial Manual.

The Toolkit resources can be used by nursing/midwifery employees individually, and the intent is that all resources will be accessible and available for use separately on the Clinical Excellence Queensland intranet page: https://qheps.health.qld.gov.au/clinical-excellence

Succession management resources

- Career pathway self-assessment activity
- Career development opportunities in the workplace

Mentoring resources

- Mentor and mentee partnership agreement
- Meeting journal sheet
- Reflective journal sheet

Mentor

- Mentor expression of
- Mentor initial self-reflection
- Mentor conversation starter guide
- Mentor evaluation tool (periodic)
- Mentor evaluation sheet (final)

Mentee

- Mentee expression of interest
- Mentee initial self-reflection
- Mentee evaluation tool (periodic)
- Mentee evaluation tool (final)

Succession Management Resources

The succession management resources can assist nursing/midwifery employees to:

- identify strengths and developmental needs in accordance with the generic domain considerations provided within the Career Pathway for the current or aspiring role/classification
- identify potential career development opportunities to support continuing professional development and career progression.

Succession management resources include:

- Career Pathway Self-Assessment Activity
- Career Development Opportunities in the Workplace.

Career Pathway Self-Assessment Activity

The ***Career Pathway Self-Assessment Activity*** provides nurses/midwives with an opportunity to identify strengths and developmental needs in accordance with the generic domain considerations provided within the Career Pathway for current or aspiring role/classifications. This tool supports the effective management of succession and establishment of an individually tailored program for career development.

Once completed, the ***Career Pathway Self-Assessment Activity*** should be discussed with the line manager and/or chosen mentor (if applicable) to determine the goals, direction and strategies for professional and career development through Performance and Development Planning (PDP) and mentoring support (if applicable). If preferred, the PDP Agreement can be used to document the activity outcomes.

Instructions:

1. Access the relevant Career Pathway for the role that you wish to further develop in, or aspire to attain:
   - Grade 5
   - Grace 6 Band 1
   - Grade 6 Band 2
   - Grade 7
   - Nurse Practitioner Candidate
   - Grade 8
   - Grade 9
   - Grade 10
   - Grade 11
   - Grade 12
   - Grade 13 Band 1
   - Grade 13 Band 2
2. Individually consider and assess your ability to demonstrate the elements contained within the five (5) Career Pathway domain considerations, including clinical, education, leadership, system supports and research, for the chosen Career Pathway.
3. Identify your strength/s and developmental need/s for each domain.
4. Discuss the outcomes with your line manager and/or chosen mentor (if applicable) to determine the goals, direction and strategies for professional and career development. You may refer to the Career Development Opportunities in the Workplace resource to assist you during this process.

DOMAIN	STRENGTH	DEVELOPMENTAL NEED
Clinical		
Education		
Leadership		
System Supports		
Research		

Employee Name	*Position*	*Work Unit*	*Facility*
Signature:			

Retain a copy of the Career Pathway Self-Assessment Activity with your PDP Agreement.

Career Development Opportunities in the Workplace

The ***Career Development Opportunities in the Workplace*** resource comprises a list of potential succession management/career development opportunities and their associated descriptors available to nursing/midwifery employees (refer to **Appendix 2, page 74, of *The Framework*** for additional examples of continuing professional development activities). Nursing/midwifery employees are encouraged to review the developmental opportunities provided and use the Performance and Development Planning (PDP) process, in collaboration with the line manager, to record interest in pursuing these opportunities. Nursing/midwifery employees should match the developmental opportunities with their specific needs and HHS/facility imperatives (MNHHS, 2015b).

Developmental Opportunity	Descriptor
Coaching	• observing an employee at work and providing feedback and facilitative problem-solving to enhance performance and correct deficiencies. Coaching focuses on helping an employee develop the skills and knowledge required to perform effectively (United States Office of Personnel Management, 2009).
Job Enrichment	• occurs when the employee takes on more responsibility, performing tasks that were previously done by supervisor or someone with more experience or skill (Northern Alberta Institute of Technology, 2009).
Individual Assignments	• are a useful way to gain special, in-depth expertise in competencies that are important to the role/position.
Team Assignments	• include serving on a committee, advisory panel, or project team. Employees can develop skills in working with others and accumulate a network of useful contacts.
Temporary Replacement	• involves relieving the incumbent during vacations, illness, or leaves of absence. This can help to develop a broader vision of the facility/organisation.
Job Rotation	• occurs when employees spend a predetermined length of time on a variety of functions. This may involve swapping jobs for a predetermined period of time, with each preparing the other in advance and being 'on call' to help with unexpected situations.
Lateral Transfers	• can enrich one's employment in an organisation and provide career and leadership development opportunities through a variety of new experiences and challenges.
Postgraduate Education	• should be considered to meet the educational requirements for leadership positions.
Leadership Development Programs	• training and education to prepare employees for leadership or senior management positions within a facility/organisation
External Structured Self-development Programs	• provide a supportive environment for developing interpersonal, communication and team building skills, e.g. Toastmasters.
Making Presentations & Running Meetings	• provides opportunities for employees to develop skills in planning, organising, appraising people and situations, giving and receiving information, delegating and goal setting.
Attendance at Higher-Level Staff Meetings	• allow employees to broaden their awareness of HHS/facility/directorate/service direction and values and of the skill sets that assist senior managers be successful.
Conducting Training	• develops planning and analytical skills, communication effectiveness, sensitivity to the needs and feelings of others and self-confidence.

Mentoring	• provides the opportunity for employees to spend time with a peer or supervisor, sometimes from a different organisational work unit. The mentor's role is to provide support and guidance as related to the development of the employee.
Shadowing	• is designed to increase career awareness and assists the employee to learn about a job by walking through the work day as a shadow to a competent worker. The shadow witnesses firsthand the work environment, employability and occupational skills in practice.
Secondment	• involves transfer from your current role to a new position for a set period to complete a project or task.
On-the-Job Training	• employee training at the place of work while he or she is doing the actual job. This is usually supported by an experienced staff member or supervisor.
Action Learning	• is learning from concrete experience and critical reflection on that experience. It is a process by which individuals/groups of people address actual workplace issues or problems, in complex situations and conditions. The benefits are great because the people participating accept that they actually own their own problems and their own solutions.
Communities of Practice	• groups of individuals who share knowledge about common work practices, though they are not part of a formally constituted work team. Communities of practice generally cut across traditional organisational boundaries and enable individuals to acquire new knowledge faster (Department of Administrative Services, 2009).
Studying Manuals & Internal Documents	• helps the employee to understand the goals, standards, and culture of the HHS/facility/directorate/service.
Structured Discussions with Peers or Subordinates	• provides employees with the opportunity to exchange information and expertise with other staff. Experts from inside/outside the facility/organisation could be invited to the group to share new knowledge or skills.
Volunteer Work	• provides many opportunities to learn about and experience leadership.
Technical/Professional Association	• participation will keep employees up-to-date with the technical side of their jobs. Involvement in committee work, specifically in leadership roles, will provide valuable experience in developing managerial competencies.
Skill Set Assessments	• provides information that is useful in assessing developmental needs.
Education Leave (SARAS)	• provides an opportunity for employees to continue to develop and grow in their careers.
In-service	• provides an opportunity for employees to participate in a variety of workshops. The intent is to offer sessions that meet current and future professional and personal development needs.
Projects	• require collaboration and participatory decision-making that is pivotal to leadership development (Cziraki et al., 2018).
Conferences, Workshops, Seminars & Conventions	• may provide employees with professional developmental opportunities tailored to the aspiring leader and opportunities to accumulate a network of useful contacts.

(MNHHS, 2015a, p. 12–14)

Mentoring Toolkit

The mentoring resources assist mentors and mentees to:

- express interest in pursuing the mentor or mentee role
- establish goals and expectations for the mentoring relationship
- keep a record of meeting discussion points
- support feedback and self-reflection
- evaluate the mentoring relationship.

The resources also assist to inform and support the development of a formal mentoring relationship. Copies of all resources should be retained with the respective Performance and Development Planning (PDP) Agreement.

Mentoring resources include:

- Mentor & Mentee Partnership Agreement
- Meeting Journal Sheet
- Reflective Journal Sheet

Mentor:

- Mentor Expression of Interest
- Mentor Initial Self Reflection
- Mentor Conversation Starter Guide
- Mentor Evaluation Tool (Periodic)
- Mentor Evaluation Tool (Final)

Mentee:

- Mentee Expression of Interest
- Mentee Initial Self Reflection
- Mentee Evaluation Tool (Periodic)
- Mentee Evaluation Tool (Final)

Mentor & Mentee Partnership Agreement

The ***Mentor & Mentee Partnership Agreement*** is used to formally establish the mentoring relationship and is a means to identify and articulate the goals, expectations and ground rules for the relationship. The Agreement aims to create a mutual understanding of how the relationship will work and function and should be reviewed regularly and renegotiated (if required) as the relationship develops and individual goals, needs and circumstances change.

I, _____ (mentor) and _____ (mentee) have agreed to enter voluntarily into this mentoring relationship which is expected to benefit individual, professional and organisational development.

Career Development Goals *Ensure goals are SMART (specific, measurable, attainable, realistic, time-bound)* Include short- and long-term goals	1. 2. 3.	
Meeting frequency/ length		
Communication method/s	Face-to-face meeting ☐ Phone ☐	Email ☐ Other ☐ _____
Predicted duration of mentoring relationship		

Mentee:

1. I understand my responsibility in leading the mentoring relationship.
2. I will participate in confidential, honest, respectful and relevant conversations.
3. I will make myself available and understand that mentoring will require me to commit time for the specified agreed period (if applicable).

Mentor:

1. I understand my responsibility in making myself available to support and develop the mentoring relationship.
2. I will participate in confidential, honest, respectful and relevant conversations.
3. I agree to support the mentee and understand that mentoring will require me to commit time for the specified agreed period (if applicable).

While we both agree to commit to, and engage in, the mentoring relationship, we understand that the relationship can be ended at any time by either the mentor or mentee on a no-fault basis.

Mentor Name	Signature	Date
Mentee Name	**Signature**	**Date**

Adapted from DDHHS (2018), GCHHS (2018a) and SCHHS (2018).

Provide the Mentor & Mentee Partnership Agreement to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) or line manager and retain a copy with your PDP Agreement.

Meeting Journal Sheet

Mentors and mentees are encouraged to use the ***Meeting Journal Sheet*** to document meeting discussion points, issues, actions, achievements and future agenda items. To preserve confidentiality, copies of the ***Meeting Journal Sheet*** should be stored in a secure location agreed upon by the mentor and mentee.

Meeting Date, Time & Location:

_____

Topics covered		
Current issues		
Current actions		
Achievements to date		
Future agenda items		
Mentor Name	***Signature***	***Date***
Mentee Name	***Signature***	***Date***

Next Meeting Date, Time & Location: _____

Adapted from DDHHS (2018).

Reflective Journal Sheet

The ***Reflective Journal Sheet*** supports the mentor and mentee engagement in self-reflection to facilitate personal and professional growth. The analysis of experiences in a reflection journal can assist individuals to make sense of situations and feelings, consider what else could have been done and identify areas for self-improvement. Mentors and mentees should retain a copy of their ***Reflective Journal Sheet*** in a secure location.

Meeting Date and Time: _____

Meeting Location: _____

New learning: *Consider:* • *What was challenging or difficult to understand?* • *How is this new learning relevant to my practice?* • *How will it be useful moving forward?*	
What worked well?	
What didn't work well? Why?	
Where to next? *Consider:* • *Knowledge deficits/gaps* • *Strategies for professional/ career development*	

Name	***Signature***	***Date***

Adapted from GCHHS (2018b) and MNHHS (2015b).

Mentor Expression of Interest

The ***Mentor Expression of Interest*** assists the Mentoring Coordinator/Champion/Delegate (if sponsored) to effectively and appropriately match mentors and mentees based on common interests and values. To preserve confidentiality, copies of the ***Mentor Expression of Interest*** should be stored in a secure location.

Have you undertaken a mentor role previously? Yes ☐ No ☐	
Name	
Employing facility	
Current position	
Length of time in position	
Length of career	
Qualifications	
Career summary	
Area\s of interest	
Why do you want to be a mentor?	
Contact details	Phone number: Mobile number: Email address: Preferred contact method: Work phone ☐ Mobile phone ☐ Email ☐
Signature	***Date***

Adapted from CHQHHS (n.d.) and MNHHS (2015a).

Provide the Mentor Expression of Interest to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) and retain a copy with your PDP Agreement.

Mentor Initial Self Reflection

The mentor is encouraged to complete the ***Mentor Initial Self Reflection*** prior to the initial mentoring meeting to explore their individual needs, interests, concerns and expectations regarding the mentoring relationship. The mentor is encouraged to provide the ***Mentor Initial Self Reflection*** to the Mentoring Coordinator/Champion/Delegate (if sponsored) to inform training and development strategies for mentors.

NEEDS – *What are your present needs as a mentor?*
INTERESTS – *What are your main interests and skills?*
CONCERNS – *What are your concerns with regard to your role as a mentor?*
EXPECTATIONS – *What are your expectations of the mentoring relationship?*

Name	***Signature***	***Date***

Adapted from Cunningham Centre DDHHS (2018) and SCHHS (2016).

Provide the Mentor Initial Self Reflection to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) and retain a copy with your PDP Agreement.

Mentor Conversation Starter Guide

The purpose of the ***Mentor Conversation Starter Guide*** is to support mentors to engage in meaningful conversations with their mentee. Mentors can use the following questions and statements to assist their mentee to identify and describe problems and situations, reflect on their feelings, assumptions and beliefs, identify alternatives and other options that may have not been considered and come to a new understanding about themselves or issues they are experiencing. In addition, there are questions and statements to support the mentor to assess for mentee understanding, willingness to listen and to monitor the mentoring relationship and achievement of goals.

Investigative questions – Seek information and objective facts

- What do you think is the cause?
- What have you done so far to address it?
- What has happened since we last met? Where are you now?
- What resources will you need?
- What barriers or challenges can you anticipate?
- What is the situation/problem/issue?
- What has worked so far? What has not worked?
- What went well? What needs work?
- What is your current situation?
- What do you know and what else do you need to know?
- Who else is involved?
- How long have you been working on this?
- When do you think you lost focus?

Discovery questions – Encourage mentee to reflect upon their knowledge, experience and insight

- What did you learn (from an experience, about yourself, about others, about a situation)?
- What will you do with this knowledge?
- What steps do you plan to take to accomplish those goals? How are you going to get there?
- What are your desired outcomes?
- How will your goals be achieved?
- What have you learned from this experience?

Empowering questions – Explore what happens next

- What would you like to accomplish (before we meet next time)?
- What could you do (differently) to get your desired result?
- How can I help you to be successful?
- How will you monitor your progress?
- What is your next step?
- What could be done differently next time?

Potential statements to assess for mentee understanding

- What I heard you say is…
- What I can gather is that…
- If I have understood you correctly, what you are saying is that…

Potential questions to assess for mentee willingness to listen

- Can I offer you some feedback?
- Are you open to receiving feedback?
- May I provide some suggestions?
- How do you feel about receiving some feedback on this?

Potential questions to monitor the development of the relationship and the achievement of goals

- Are we meeting the established goals?
- Are we both engaged in this mentoring relationship?
- Are we both taking equal responsibility in this mentoring relationship?
- What have we achieved so far?
- What have our challenges been so far?
- Are we enjoying this mentoring relationship process?
- What are the current concerns or frustrations?

Adapted from AQNML (2013), DDHHS (2018), GCHHS (2018b), RCH (2015) and University of Washington (n.d.).

Mentor Evaluation Tool (Periodic)

The ***Mentor Evaluation Tool (Periodic)*** has been designed to provide the mentor with an opportunity to deliver feedback on their mentee's performance and engagement with the mentoring process, their mentoring ability and the mentor program (if applicable). The mentor is encouraged to complete ***Mentor Evaluation Tool (Periodic)*** at 3, 6, 9 and 12-month intervals.

Provide the Mentor Evaluation Tool to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) and retain a copy with your PDP Agreement.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable or No Comment
Feedback on Mentee						
The mentee is engaged in, and committed to, the mentoring relationship						
The mentee reflects on their strengths and developmental needs to form realistic goals						
The mentee is proactive and took initiative throughout the mentoring relationship						
The mentee appropriately discusses developmental priorities						
The mentee is responsible and accountable for their personal and professional development						
The mentee is accepting of, and responds appropriately to, constructive feedback						
The mentee provides constructive and honest feedback to me regarding my mentoring ability						
The mentee attends all scheduled meetings						
The mentee is prepared for all scheduled meetings						
The mentoring relationship has been a positive experience						
The mentee maintains confidentiality						
Feedback on Mentor Ability						
I feel confident in my role as a mentor						
I feel adequately prepared to function as a mentor						
Feedback on Mentor Program (if sponsored)						
I feel supported by the Mentoring Coordinator/Champion/Delegate						
I have received adequate training on mentoring						
The Mentoring Coordinator/Champion/Delegate appropriately matched me with a suitable mentee						
I would like to continue mentoring						

Name	***Signature***	***Date***

Additional comments:

Adapted from DDHHS (2018) and Queensland Health (2015).

Mentor Evaluation Tool (Final)

The ***Mentor Evaluation Tool (Final)*** has been designed to provide the mentor with an opportunity to deliver feedback on their mentee's performance and engagement with the mentoring process, their mentoring ability and the mentor program (if applicable) at the conclusion of the mentoring relationship. The mentor is encouraged to complete ***Mentor Evaluation Tool (Final)*** at the conclusion of the mentoring relationship.

Provide the Mentor Evaluation Tool to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) and retain a copy with your PDP Agreement.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable or No Comment
Feedback on Mentee						
The mentee was engaged in, and committed to, the mentoring relationship						
The mentee reflected on their strengths and developmental needs to form realistic goals						
The mentee was proactive and took initiative throughout the mentoring relationship						
The mentee appropriately discussed developmental priorities						
The mentee was responsible and accountable for their personal and professional development						
The mentee was accepting of, and responded appropriately to, constructive feedback						
The mentee provided constructive and honest feedback to me regarding my mentoring ability						
The mentee attended all scheduled meetings						
The mentee was prepared for all scheduled meetings						
The mentoring relationship was a positive experience						
The mentee maintained confidentiality						
Feedback on Mentor Ability						
I felt confident in my role as a mentor						
I felt adequately prepared to function as a mentor						
Feedback on Mentor Program (if sponsored)						
I felt supported by the Mentoring Coordinator/Champion/Delegate						
I received adequate training on mentoring						
The Mentoring Coordinator/Champion/Delegate appropriately matched me with a suitable mentee						
I would like to mentor again						

Name	***Signature***	***Date***

Additional comments:

Adapted from DDHHS (2018) and Queensland Health (2015).

Mentee Expression of Interest

The ***Mentee Expression of Interest*** assists the Mentoring Coordinator/Champion/Delegate (if sponsored) to effectively and appropriately match mentors and mentees based on common interests and values. To preserve confidentiality, copies of the ***Mentee Expression of Interest*** should be stored in a secure location.

Have you received mentoring previously? Yes ☐ No ☐				
Name				
Employing facility				
Current position				
Length of time in position				
Career summary				
Career development interests and/or gaps	Clinical	☐	Human Resource Management	☐
	Career Planning	☐	People Management	☐
	Leadership	☐	Change Management	☐
	Communication (Circle: interpersonal/verbal/ presentation/written)	☐	Project Management	☐
			Conflict Management	☐
	Corporate Knowledge	☐	Digital Technology	☐
	Education and continuing professional development	☐	Research	☐
	Performance Improvement Processes	☐	Quality Improvement and Risk Management	☐
	Performance Development and Planning Processes	☐	Finance	☐
	Accreditation/ACHS	☐	Job Application and/or Interview Support	☐
	Auditing	☐	Other:	☐
What style/character are you seeking in a mentor?				
Contact details	Phone number: Mobile number: Email address: Preferred contact method: Work phone ☐ Mobile phone ☐ Email ☐			
Signature		***Date***		

Adapted from GCHHS (n.d.).

Provide the Mentee Expression of Interest to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored).

Mentee Initial Self Reflection

The mentee is encouraged to complete the ***Mentee Initial Self Reflection*** prior to the initial mentoring meeting to explore their individual needs, interests, concerns and expectations regarding the mentoring relationship. The ***Mentee Initial Self Reflection*** can be referred to during the first meeting to assist in forming the basis and structure of the mentoring relationship. The mentee is encouraged to provide the ***Mentee Initial Self Reflection*** to the Mentoring Coordinator/Champion/Delegate (if sponsored) to inform training and development strategies for mentors.

NEEDS – *What are your present needs as a mentee?*		
INTERESTS – *What are your main interests with regard to your work?*		
CONCERNS – *What are your concerns with regard to your role as a mentee?*		
EXPECTATIONS – *What are your expectations of the mentoring relationship?*		
Name	***Signature***	***Date***

Adapted from SCHHS (2016).

Provide the Mentee Initial Self Reflection to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) and retain a copy with your PDP Agreement.

Mentee Evaluation Tool (Periodic)

The ***Mentee Evaluation Tool (Periodic)*** has been designed to provide the mentee with an opportunity to deliver feedback on their mentor's performance and engagement with the mentoring process and on their personal development at set intervals throughout the mentoring relationship. The mentee is encouraged to complete ***Mentee Evaluation Tool (Periodic)*** at 3, 6, 9 and 12-month intervals.

Provide the Mentee Evaluation Tool to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) and retain a copy with your PDP Agreement.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable or No Comment
Feedback on Mentor						
I have experienced no difficulty when contacting the mentor to initiate the mentoring relationship						
The mentor is approachable						
The mentor is accessible						
The mentor actively listens to me						
The mentor provides respectful feedback						
The mentor provides honest feedback						
The mentor provides constructive feedback						
The mentor promotes independence						
The mentor is supportive of my developmental goals and priorities						
The mentor attends all scheduled meetings						
The mentor is prepared for all scheduled meetings						
The mentoring relationship has been a positive experience						
The mentor maintains confidentiality						
The mentor is trustworthy						
The mentor assisted me to achieve my goals						
Feedback on Mentee Development						
I am more satisfied with my job						
I feel more socially connected in the workplace						
I feel more comfortable in the workplace						
I feel more valued in this organisation						
I feel more certain of my career path in this organisation						
My technical skills have improved						
Engaging in the mentoring relationship was worth the time and effort						

Name	***Signature***	***Date***

Additional comments:

Adapted from DDHHS (2018), National Center for Women & Information Technology (2011) and Queensland Health (2015).

Mentee Evaluation Tool (Final)

The ***Mentee Evaluation Tool (Final)*** has been designed to provide the mentee with an opportunity to deliver feedback on their mentor's performance and engagement with the mentoring process and on their personal development at the conclusion of the mentoring relationship. The mentee is encouraged to complete ***Mentee Evaluation Tool (Final)*** at the conclusion of the mentoring relationship.

Provide the Mentee Evaluation Tool to the Mentoring Coordinator/Champion/Delegate within your HHS/facility (if sponsored) and retain a copy with your PDP Agreement.	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable or No Comment
Feedback on Mentor						
I experienced no difficulty when contacting the mentor to initiate the mentoring relationship						
The mentor was approachable						
The mentor was accessible						
The mentor actively listened to me						
The mentor provides respectful feedback						
The mentor provides honest feedback						
The mentor provides constructive feedback						
The mentor promoted independence						
The mentor was supportive of my developmental goals and priorities						
The mentor attended all scheduled meetings						
The mentor was prepared for all scheduled meetings						
The mentoring relationship was a positive experience						
The mentor maintained confidentiality						
The mentor was trustworthy						
The mentor assisted me to achieve my goals						
Feedback on Mentee Development						
I am more satisfied with my job						
I feel more socially connected in the workplace						
I feel more comfortable in the workplace						
I feel more valued in this organisation						
I feel more certain of my career path in this organisation						
My technical skills have improved						
Engaging in the mentoring relationship was worth the time and effort						

Name	***Signature***	***Date***

Additional comments:

Adapted from DDHHS (2018), National Center for Women & Information Technology (2011) and Queensland Health (2015).

Appendices

Appendix 1:

Glossary

Term	Definition
Business Planning	Systematic process for examining a HHS/facility/directorate/service and its environment in order to best allocate resources to meet service demand (MNHHS, 2015a).
Career	A process of development of the employee along a path of experience and jobs in one or more facility/services (McIlveen, 2009).
Career Development	The lifelong process of managing learning and work activities in order to live a productive and fulfilling life (Nova Scotia Public Service Commission, 2015).
Career Planning	Is the active, deliberate and tailored facilitation of an individual's career development through a process in which the individual is ultimately engaged (MNHHS, 2015b).
Career Self-Management	Is an active process that consists of: • strategic individual behaviours (e.g. applying for a career-enhancing position, learning a new skill) or joint actions with another person (e.g. establishing a mentoring relationship) • behaviours that ensure positive influences among others (e.g. self-promotion) • behaviours that balance the demands of roles and prevent transgression of boundaries (e.g. work-life balance) (Rothwell, 2010).
Clinical Learning	Clinical learning refers to the requisite knowledge, skills and attributes specified by the organisation as being essential to enable nursing and midwifery staff to demonstrate acceptable standards of practice in the delivery of patient care to achieve best practice outcomes.
Clinical Supervision	A formal process of professional support and learning between clinicians within a safe environment that enables continuous, reflective analysis of care to ensure safe, quality services and the wellbeing of the clinician (RCH, 2015).
Coaching	Coaching is a collaborative, performance-based relationship whereby a coach is assigned to a staff member to purposefully assist in the development of a specific skill/set of skills and maximise performance, learning and development (Arnold, 2016; Griffith, 2012; Jones, 2015; Medd, 2011).
Context	Context refers to the environment in which nursing/midwifery is practiced. It includes the: • patient/client characteristics and health needs and the complexity of care required by them • model of care, type of service or health facility and physical setting • amount of clinical support and/or supervision that is available • resources that are available, including the staff skill mix and level of access to other healthcare professionals (Nursing and Midwifery Board of Australia [NMBA], 2013).
Continuing Professional Development (CPD)	*CPD* (often interchanged with the terms *Lifelong Learning* or *Continuing Professional Education*) is viewed as a long-term process that includes opportunities and experiences systematically planned to promote growth and development in the profession (NMBA, 2016; Fahey & Monaghan, 2005; Ganser, 2000; Morgan et al., 2008).
Evaluation	A systematic, objective assessment of the appropriateness, efficiency and effectiveness of an activity (MNHHS, 2015a).
Generic Level Statements (GLS)	Are broad, concise statements of the duties, skills and responsibilities indicative of a given nursing/midwifery classification level (Nurses and Midwives [Queensland Health] Award – State 2015 [2018 Stage Wage Case Reprint], 2018).

Knowledge Management and Transfer	A conscious strategy of transferring the right knowledge to the right people at the right time (Calo, 2008; Edwards, 2015).
Lifelong Learning	Lifelong learning is the provision or use of both formal and informal learning opportunities throughout people's lives in order to foster the continuous development and improvement of the knowledge and skills needed for employment and personal fulfilment (Collins, 2018).
Midwife	A Midwife is an employee who appears on the *Register of Practitioners of the Australian Health Practitioners Regulation Agency (AHPRA)* as a Midwife (Nurses and Midwives [Queensland Health] Award – State 2015 [2018 Stage Wage Case Reprint], 2018).
Mentor	Someone who is recognised as a highly proficient professional who is selected by an individual or the Mentoring Coordinator/Champion/Delegate (if sponsored) to guide their development from both personal and professional perspectives (Huybrecht, Loeck, Quaeyhaegens, De Tobel, & Mistiaen, 2011; MNHHS, 2015a; Queensland Health, 2010).
Mentoring	Mentoring is a voluntary, long-term, multifaceted developmental relationship where personal, psychosocial support and career guidance is provided to the mentee by a more experienced person/s (Brewer, 2016; Groves, 2007; Ministerial Council for Education Early Childhood Development & Youth Affairs [MCEECDYA], 2014; UNSW, 2015).
Organisational Knowledge	Organisational knowledge is the collective knowledge and abilities possessed by the people who belong to an organisation. It is a distinct attribute of an organisation and is different and distinguishable from the knowledge of individuals (Spacey, 2017).
Organisational Learning	The knowledge and skills required by nurses and midwives to function effectively in their roles to achieve specific organisational aims.
Orientation	Orientation is the process by which new employees are provided with the opportunity to gain knowledge and appreciation of the HHS, including its mission, strategic objectives, corporate initiatives and scope of the health service including facilities, services and specific legislative, mandatory and requisite training and assessment (Queensland Health 2018b).
Performance and Development Planning (PDP)	PDP is the process of identifying, evaluating and developing the performance of employees in a HHS/facility/directorate/service, so that organisational goals are more effectively achieved. It also provides the mechanism whereby all employees can benefit in terms of recognition, receiving feedback, career planning and professional and personal development.
Preceptor	A Preceptor is a competent, confident and experienced practitioner who facilitates the effective transition and assimilation of a newly registered or transferred nurse/midwife to the work environment through role modelling; demonstration of supportive behaviours; identifying and addressing learning needs; and guiding practice and development (Trede, Sutton, & Bernoth, 2015; Valizadeh, Borimnejad, Rahmani, Gholizadeh, & Shabazi, 2016).
Preceptorship	Preceptorship is a formal, preplanned relationship between an experienced and newly registered/transferred nurse/midwife during which he/she is transitioned to the work environment; supported to develop their competence and confidence as an autonomous professional; refine their skills, values and behaviours; and continue their journey of lifelong learning (Valizadeh et al., 2016; Whitehead, Owen, Henshaw, Beddingham, & Simmons, 2015).
Professional Learning	The learning that the nurse/midwifes engages in relative to broader professional issues and trends (MNHHS, 2015a).
Registered Nurse (RN)	A RN is an employee who appears on the *Register of Practitioners of the Australian Health Practitioners Regulation Agency (AHPRA)* as a Registered Nurse Division 1 (Nurses and Midwives [Queensland Health] Award – State 2015 [2018 Stage Wage Case Reprint], 2018).
Replacement Planning	Replacement planning concentrates on immediate needs and a 'snapshot' assessment of the availability of qualified candidates for key vacancies (MNHHS, 2015a).

Succession Management	Succession management is any structured effort designed to ensure the continued effective performance of a HHS/facility/service, division, department or work group by making provision for the development, replacement and strategic application of key people over time (Deloitte, 2016; Higginbottom, 2014; Victorian Public Sector Commission, 2015).
Succession Planning	Succession planning is a proactive strategy that involves activities and interventions to ensure that capable, motivated and talented employees are ready to assume leadership roles for which they have been selected/identified as suitable (Griffith, 2012; Trepanier & Crenshaw, 2013; Vanvactor, 2015).
Transition	Transition is the period of learning and adjustment in which the new staff member acquires the skills, knowledge and values required to become an effective member of the healthcare team (Fox, Henderson, & Malko-Nyhan, 2005; MNHHS, 2015a; Queensland Health 2011).
Workforce Capability	Workforce capability refers to the HHS/facility/service ability to accomplish its work processes through knowledge, skills, abilities and competencies of its people (Australian Public Service, 2012).
Workforce Planning	Workforce planning is the systematic identification and analysis of what an HHS/facility/service is going to need in terms of size, type and quality of workforce to achieve its objectives (Australian Public Service, 2012).
Work Unit Developmental Map	A Work Unit Development Map, a form of a learning pathway, has been recognised as a useful resource to assist nursing/midwifery employees to meet their individual learning needs. A Work Unit Development Map diagrammatically summarises the key clinical, professional and organisational learning required for a specific role (Queensland Health, 2018a).

(Queensland Health, 2018a, p. 69–74)

Appendix 2:

Standards for Succession Management

Succession Management strategies are used to foster the career development of individual nurses/midwives, attain and maintain a sustainable workforce, and assist in achieving organisational goals (CPS HR Consulting, 2017; Higginbottom, 2014; Underhill, 2017).

- Nursing/Midwifery governance apply succession management principles in striving for a pool of talented staff who can add value to a diverse, professional and capable workforce (Aon Hewitt, 2012; Deloitte, 2016; Higginbottom, 2014; Underhill, 2017).
- Succession management is applied appropriately as an essential strategy for future organisational success, capacity building, retention, recruitment and career development (CPS HR Consulting, 2017; Higginbottom, 2014; Rothwell, 2010; Underhill, 2017).
- HHS, facilities/directorate/services demonstrate commitment to developing, assigning and promoting nurses/midwives via both internal and external career development opportunities and talent pool recognition (Aon Hewitt, 2012; Deloitte, 2016; Underhill, 2017).
- Line Managers are responsible for open and honest discussions with employees about development needs, succession management potential, opportunities and possible barriers to achievement of succession management and career development goals (Aon Hewitt, 2012; MNHHS, 2015a & 2015b; Queensland Health, 2013b & 2014b; Underhill, 2017).
- Succession management is an integral part of the facility/directorate/service/unit's business strategy and is linked to an employee's PDP (Aon Hewitt, 2012; CPS HR Consulting, 2017; Deloitte, 2016; MNHHS, 2015a & 2015b; Queensland Health, 2013b & 2014b).
- Employees are encouraged to participate in self-assessment of skills, values, interests and development needs to inform (as relevant) succession management plans (Aon Hewitt, 2012; CPS HR Consulting, 2017; MNHHS, 2015a & 2015b; Queensland Health, 2013b & 2014b).

To achieve effective supporting relationships, it important that underpinning support systems such as (however not limited to) PDP and Advanced Standing/Recognition of Prior Learning (RPL) are in place.

(Queensland Health, 2018a, p. 59).

Refer to **Section 12.6, page 59, of *The Framework***.

Standards for Mentoring

Mentoring is established, maintained and supported as per HHS, facility/directorate/service process to promote capacity building, nurse/midwifery career development (Brewer, 2016; Ehrich, 2013; SSSC, 2014).

- Nursing/midwifery governance sponsors mentoring for nurse/midwives via the application of pre-determined processes, frameworks and other resources.
- Nursing/midwifery governance determines a means for matching mentors and mentees as per specific HHS, facility/directorate/service processes. (Brewer, 2016; Groves, 2007; Heartfield, Gibson, Chestman & Tagg, 2005; MNHHS, 2015a; SSSC, 2014).
- Nursing/midwifery colleagues undertaking a mentor role are provided training opportunities.
- The development and tracking of a pool of suitably trained and prepared mentors occurs as per endorsed HHS/facility/directorate/service processes (Brewer, 2016; MNHHS, 2015a & 2015b; SSSC, 2014).
- The mentoring relationship is founded on intentional learning whereby the mentor assists through instructing, coaching, providing experiences, modelling and advising (Brewer, 2016; Ehrich, 2013; SSSC, 2014).
- Line Managers and Nurse/Midwifery Educators promote mentorship and facilitate opportunities for the mentor and mentee to participate in the mentoring relationship/discussions (Brewer, 2016; Ehrich, 2013; MNHHS, 2015a; SSSC, 2014).
- Line Managers provide feedback to the mentee and mentor (as appropriate) regarding the changes they have observed in the mentee and their performance (Brewer, 2016; Ehrich, 2013; MNHHS, 2015a; SSSC, 2014).
- Mentor training, support, development and feedback processes are evaluated and modified to improve return on expectations.

Mentoring can contribute to the engagement, motivation, morale, wellbeing, career mobility, and leadership capacity of mentees and mentors and impact positively on the organisation (Brewer, 2016; SSSC, 2014). It can also be an effective strategy for enriching succession management. Mentors paired with individuals being succession managed will complement succession planning goals and facilitate capacity. Additionally, experienced employee expertise will not be lost once they retire or leave the organisation but be retained through being shared by those who are poised to take their place (Ehrich, 2013; SSSC, 2014).

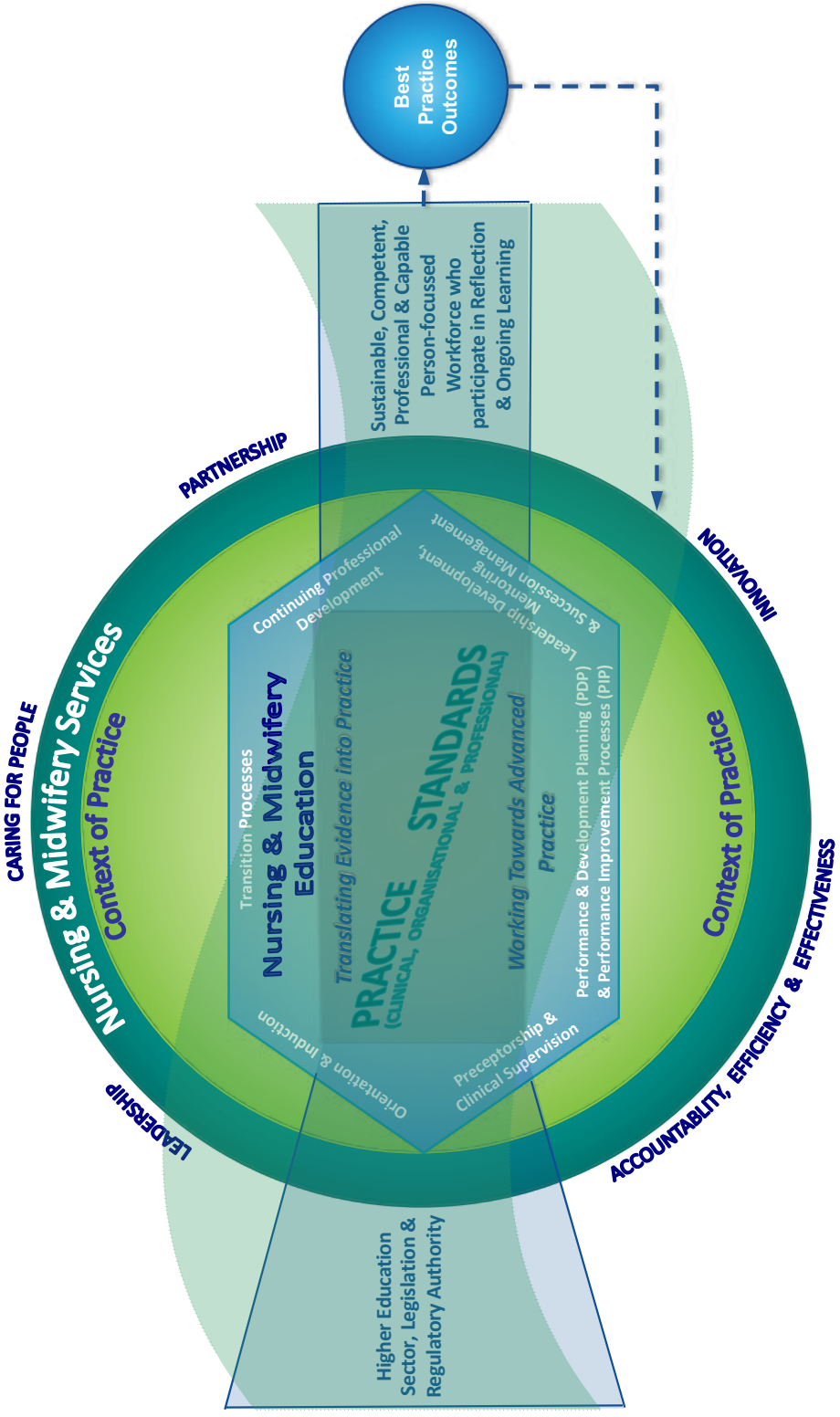
(Queensland Health, 2018a, p. 56–57).

Refer to **Section 12.5, page 56, of *The Framework***.

Appendix 3:

Nursing and Midwifery Education Model – Example

The Queensland Health Nursing & Midwifery Education Model (refer **to Section 6, page 12, of *The Framework***) has been designed to assist nursing/midwifery stakeholders in understanding the internal and external influences, factors and processes that impact nursing/midwifery education engagement, actions and outcomes. As depicted, the primary responsibilities of Nurse/Midwifery Educators are outlined around the border of the blue hexagon (e.g. leadership development, succession management and mentoring), which demonstrates the complexity of the core nursing/midwifery activities and the profession's common goal towards the advancement of practice (Queensland Health, 2018a, p. 12). Additional information on the model is located on pages 11–14 of *The Framework*.

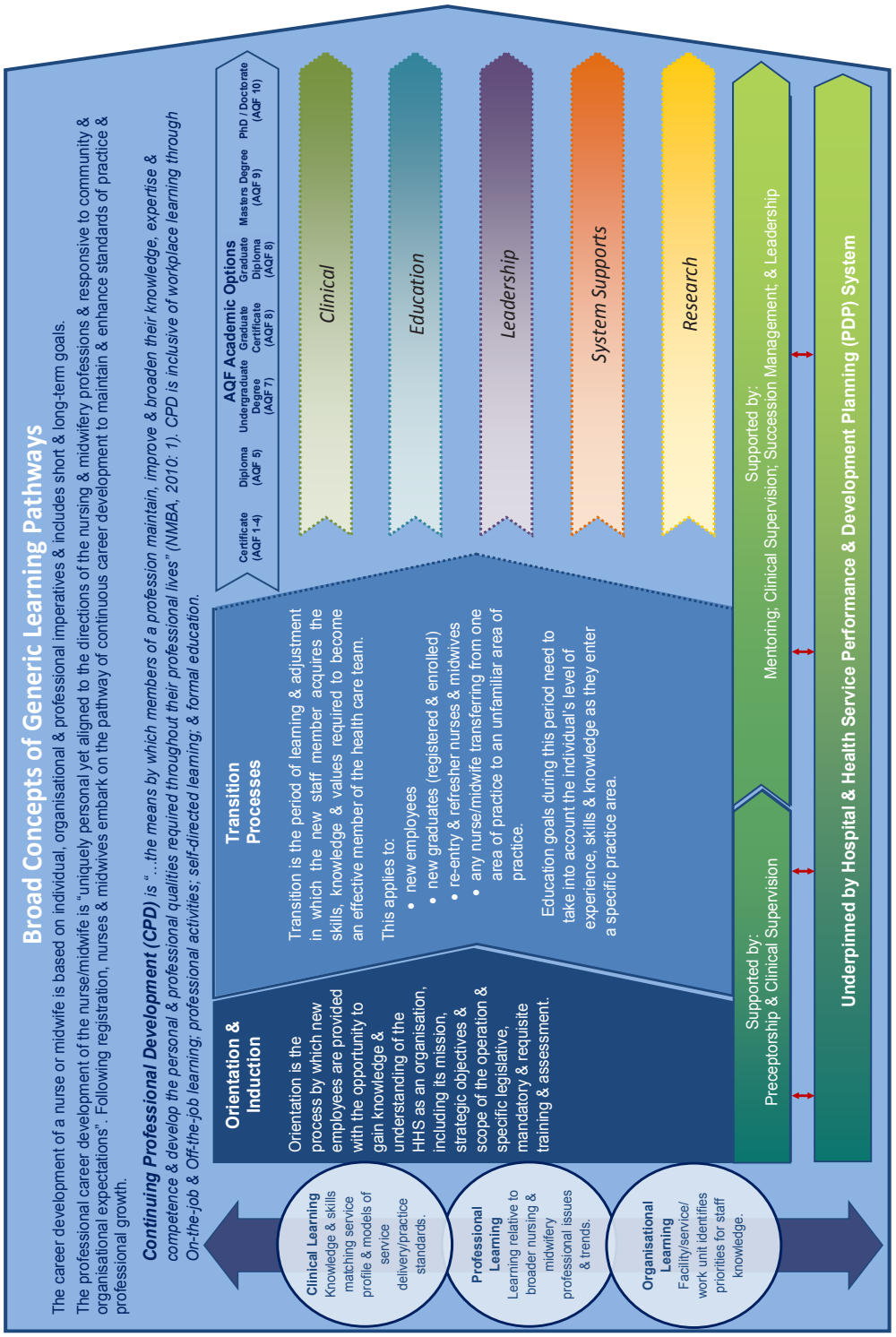


N.B. While the Queensland Health core values are depicted in this model, these can be added to, or substituted, with HHS, facility, directorate or service values or nursing and midwifery values.

Appendix 4:

Broad Concepts of Generic Learning Pathways

The Broad Concepts of Generic Learning Pathways Model (refer to Section 8.2.2, page 26, of The Framework) provides a schematic representation of a progressive learning pathway and illustrates how continuing professional development and the advancement of a learning culture can be applied to support the careers of the nursing/midwifery profession. The pathway is structured to depict the different strategies required to provide learning and development opportunities in a structured manner. As depicted in the model, an individual's progressive learning pathway is supported by mentoring, clinical supervision, succession management and leadership (Queensland Health, 2018a, p. 26). Additional information on the Model is located on page 25 of The Framework.

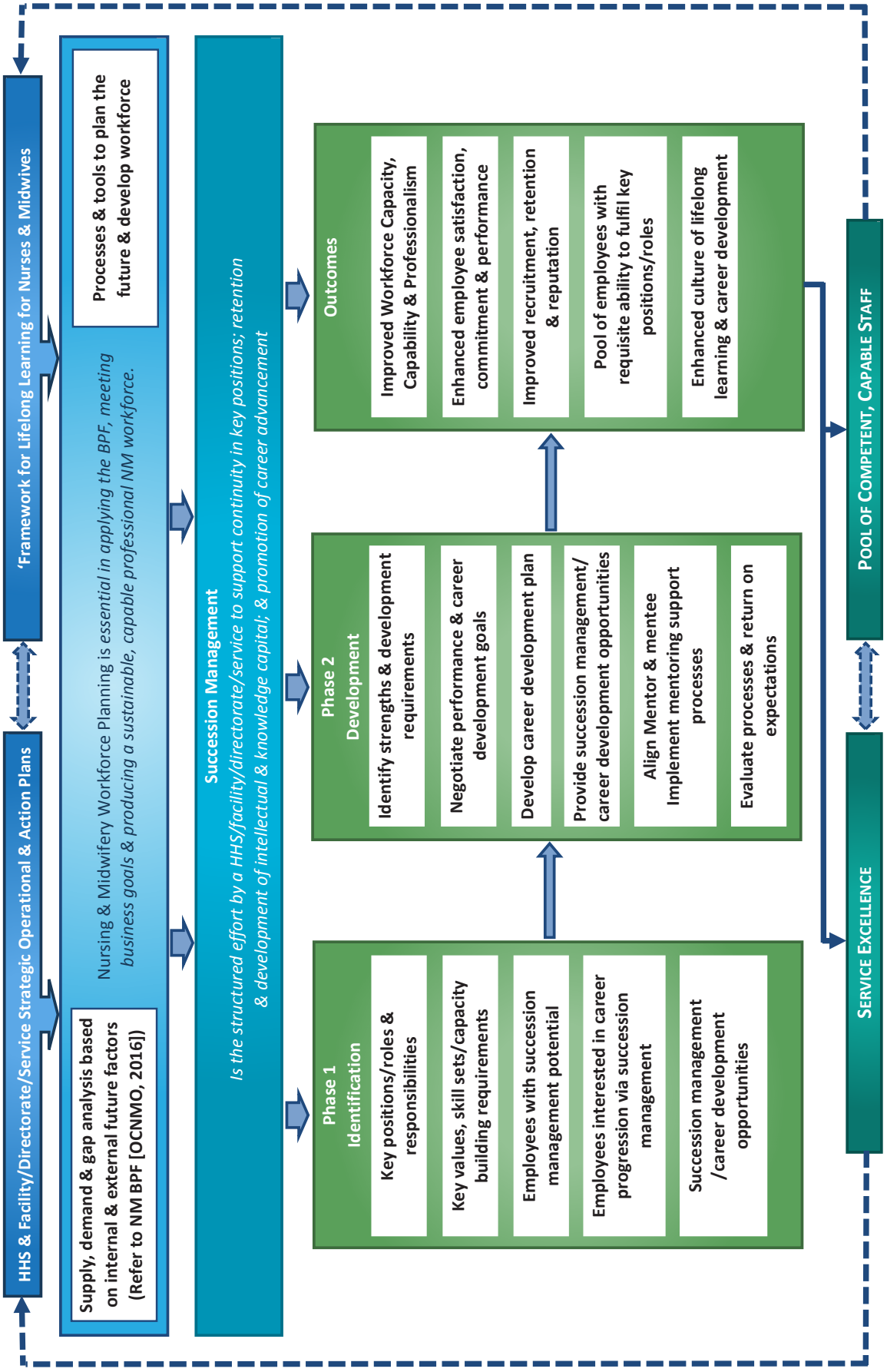


Model adapted from MNHHS (2015c)

Appendix 5:

Diagrammatic Representation of Succession Management

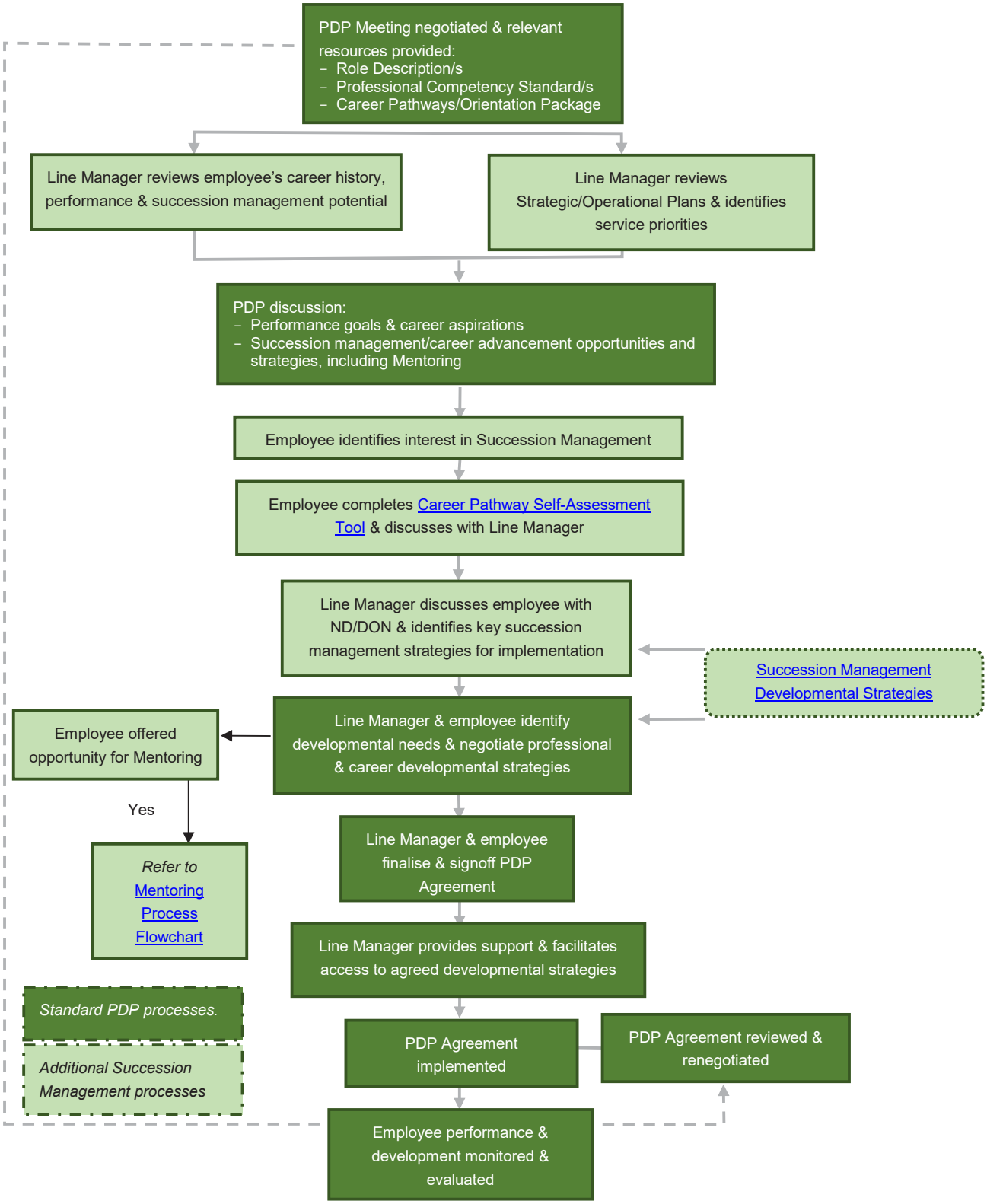
Adapted from Innovation & Growth (2012).



Appendix 6:

Succession Management and PDP Flowchart

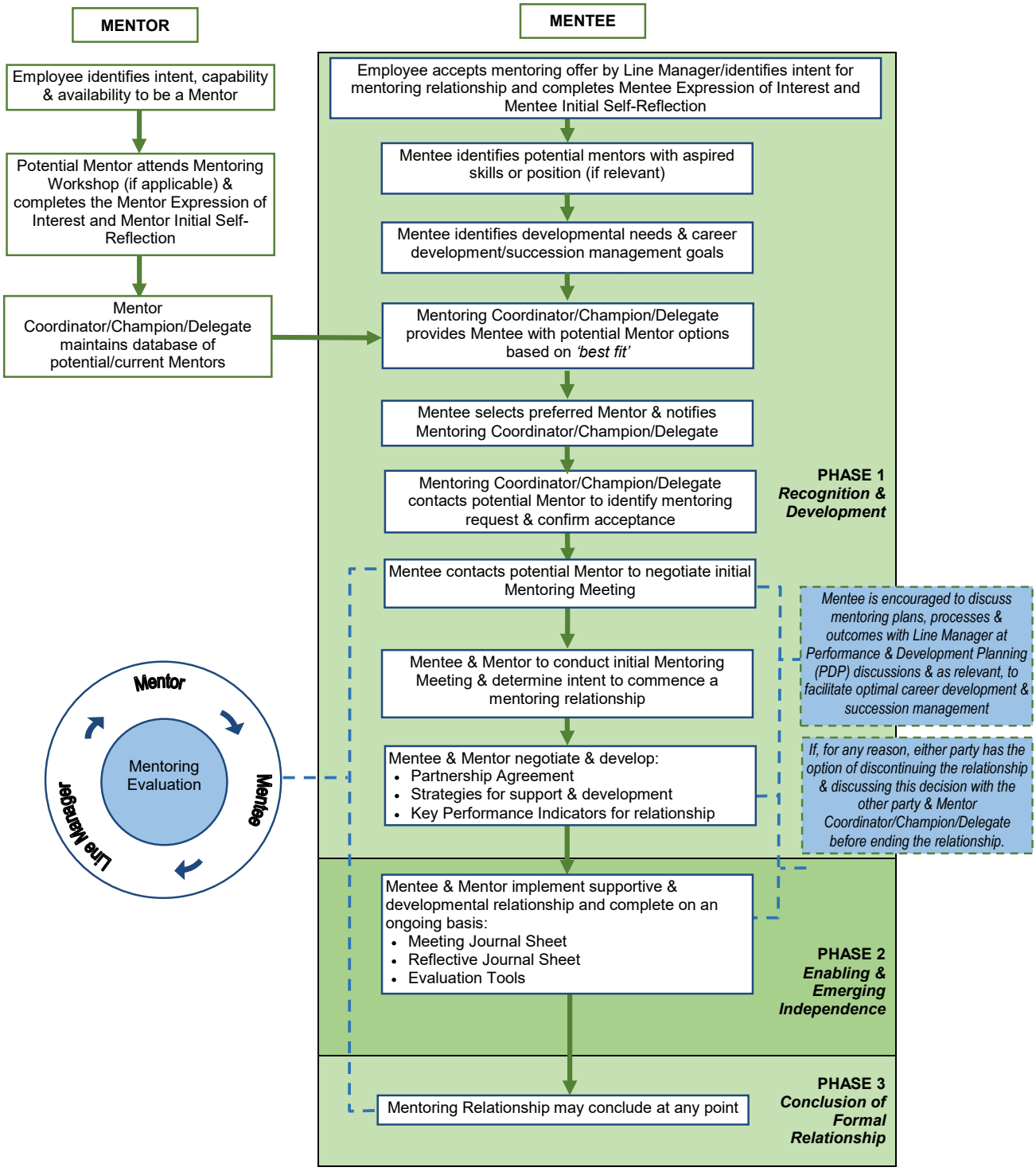
(MNHHS, 2015a, p. 25)



Appendix 7:

Mentoring Process Flowchart

(MNHHS, 2015a, p. 37)



Appendix 8:

Mentor and Mentee Characteristics, Abilities and Attitudes

While each individual mentor and mentee will bring their individual personality, expertise, attitudes, values and beliefs to the relationship, the desirable characteristics, abilities and attitudes of each role are presented in the following table:

Mentor Characteristics	Mentor Abilities and Attitudes
• Confident (Verret & Lin, 2016) • Positive attitude (Zhang et al., 2016) • Approachable and accessible (Hodgson & Scanlan, 2013; SCHHS, n.d.-b; Vinales, 2015) • Experienced, knowledgeable and competent • Open and honest (Hodgson & Scanlan, 2013) • Trustworthy (Lipscomb & An, 2013) • Friendly and respectful • Patient and calm (Hodgson & Scanlan, 2013; Vinales, 2015) • Enthusiastic (Hodgson & Scanlan, 2013; Huybrecht et al., 2011) • Risk taker (McBride et al., 2017) • Selfless • Visionary • Politically astute • Aware of organisational culture • Supportive • Loyal (SCHHS, n.d. b) • Inspirational and motivational • Assertive • Realistic • Opportunistic (MNHHS, 2015a)	• Committed to the development of others (Verret & Lin, 2016; Zhang et al., 2016) • Authority and experience in the field (Hodgson & Scanlan, 2013; SCHHS, n.d.-b) • Educator – able to teach and provide guidance • Counsellor • Sponsor (Zhang et al., 2016) • Active listener (Lipscomb & An, 2013; UNSW, 2015) • Aspirational thinker (Verret & Lin, 2016) • Willing to commit time and energy to develop supportive relationship • Able to develop confidence • Demonstrates leadership • Displays integrity • Stimulates enthusiasm • Identifies opportunities • Able to see potential in others • Acts as a role model • Provides constructive feedback • Able to challenge, analyse and evaluate • View problems and issues differently • Challenges assumptions (MNHHS, 2015a)
Mentee Characteristics	**Mentee Abilities and Attitudes**
• Takes initiative • Committed to learning, development and career growth • Positive self-identity • Motivated and determined • Goal-driven and ambitious • Passionate • Open to support and teaching • Potential to succeed • Independent • Accountable • Open and honest (SCHHS, n.d.-a) • Respectful • Risk taker (MNHHS, 2015a)	• Proactive • Willing to invest time and energy to build a relationship • Listens and communicates effectively • Willing to receive constructive feedback • Considers and works with different opinions • Able to work autonomously • Displays attempts to develop own solutions • Patient • Actively identifies and pursues self-development • Acts on new knowledge and skills • Willing to seek out and accept broader responsibilities • Able to work alongside or under direction • Acts responsibly (MNHHS, 2015a)

References

Acree-Hamann, C. (2016). A Call to Action: Succession Planning Needed. *Newborn and Infant Nursing Reviews, 16*(3), 161-163. doi:10.1053/j.nainr.2016.07.001.

Arnold, J. (2016). Coaching Skills for Leaders in the Workplace: How to unlock potential and maximise performance. London, UK: Little Brown Book Group.

Association of Queensland Nursing and Midwifery Leaders (AQNML). (2013). AQNML Mentoring Framework and Toolkit. Brisbane, QLD: AQNML.

Australian Public Service. (2012). Australian Public Service (APS) Workforce Planning Guide. Canberra, ACT: Australian Government.

Bond University. (2018). Academic Coaching Workshops: Coaching@Bond. Gold Coast, QLD: Bond University.

Booker, C., Turbutt, A., & Fox, R. (2016). Model of care for a changing healthcare system: are there foundational pillars for design? *Australian Health Review, 40*(2), 136-140.

Brewer, A. M. (2016). Mentoring from a Positive Psychology Perspective. Syndey, NSW: Springer International Publishing.

Brody, A. A., Edelman, L., Siegel, E. O., Foster, V., Bailey, D. E., Jr., Bryant, A. L., & Bond, S. M. (2016). Evaluation of a peer mentoring program for early career gerontological nursing faculty and its potential for application to other fields in nursing and health sciences. *Nursing Outlook, 64*(4), 332-338. doi:10.1016/j.outlook.2016.03.004.

Brunero, S., Kerr, S., & Jastrzab, G. (2009). The development and evaluation of a succession planning programme in nursing, in Australia. *Journal of Nursing Management, 17*, 576-583. doi:10.1111/j.1365-2834.2009.00990.x.

Burgess, A., van Diggele, C., & Mellis, C. (2018). Mentorship in the Health Professions: A Review. *The Clinical Teacher, 15*, 197-202.

Calo, T. J. (2008). Talent Management in the Era of the Aging Workforce: The Critical Role of Knowledge Transfer. *Public Personnel Management, 37*(4), 403-416.

Central Queensland Hospital and Health Service (CQHHS). (n.d.). Succession Planning Process. Central Queensland: CQHHS Human Resources Unit.

Chen, Y., Watson, R., & Hilton, A. (2016). A review of mentorship measurement tools. *Nurse Education Today, 40*, 20-28. doi:10.1016/j.nedt.2016.01.020.

Children's Health Queensland Hospital and Health Service (CHQHHS). (2015a). Executive and Senior Succession Management Program - Checklist and Resources. Retrieved from https://qheps.health.qld.gov.au/data/assets/pdf_file/0028/750484/esl-succession-mgt-cl.pdf.

CHQHHS. (2015b). Mentoring Program for CHQ Nurses. Brisbane, QLD: State of Queensland (Queensland Health).

CHQHHS. (n.d.). CHQ Mentor Application Form. Brisbane, QLD: State of Queensland (Queensland Health).

Collins English Dictionary. (2018). 'lifelong learning'. Sydney, NSW: HarperCollins Publishers.

Collins English Dictionary. (2018). 'tookit'. Sydney, NSW: HarperCollins Publishers.

CPS HR Consulting. (2017). Succession Planning: Preparing for your Agency's Future. Sacramento, CA: CPS HR Consulting.

Cummins, A. M., Denney-Wilson, E., & Homer, C. S. E. (2017). The mentoring experiences of new graduate midwives working in midwifery continuity of care models in Australia. *Nurse Education in Practice, 24*, 106-111. doi:10.1016/j.nepr.2016.01.003.

Cunningham Centre Darling Downs Hospital and Health Service (DDHHS). (2018). Preparation for the mentor. Toowoomba, QLD: State of Queensland (Queensland Health).

Cziraki, K., Read, E., Spence Laschinger, H. K., & Wong, C. (2018). Nurses' leadership self-efficacy, motivation, and career aspirations. *Leadership in Health Services, 31*(1), 47-61. doi:10.1108/lhs-02-2017-0003.

Dalglish, C. (2010). Leadership: Understanding its Global Impact. Prahran, VIC: Tilde University Press.

Darling Downs Hospital and Health Service (DDHHS). (2018). Nursing and Midwifery Mentoring Program. Toowoomba, QLD: State of Queensland (Queensland Health).

Deloitte. (2016). Succession Management - Developing the next generation of Federal leaders. New York: Deloitte Development LLC.

Denker, A. L., Sherman, R. O., Hutton-Woodland, M., Brunell, M. L., & Medina, P. (2015). Florida Nurse Leader Survey Findings: Key Leadership Competencies, Barriers to Leadership, and Succession Planning Needs. *Journal of Nursing Administration, 45*(7-8), 404-410. doi:10.1097/nna.0000000000000222.

Department of Administrative Services. (2009). Workforce Development Definitions. Retrieved from http://www.admin.state.nh.us/hr/documents/WorkforceDevelopment/worforcedevelopmentdefinitions.doc.

Dopson, S. A., Griffey, S., Ghiya, N., Laird, S., Cyphert, A., & Iskander, J. (2017). Structured Mentoring for Workforce Engagement and Professional Development in Public Health Settings. *Health Promotion Practice, 18*(3), 327-331. doi:10.1177/1524839916686927.

Edwards, J. S. (2015). The Essentials of Knowledge Management. London, UK: Palgrave Macmillan. doi:10.1057/9781137552105.

Fahey, C., & Monaghan, J. (2005). Australian rural midwives' perspectives on continuing professional development. *The International Electronic Journal of Rural and Remote Health, Research, Education, Practice and Policy.* Retrieved from http://rrh.deakin.edu.au.

Fountain, J., & Newcomer, K. E. (2016). Developing and sustaining effective faculty mentoring programs. *Journal of Public Affairs Education, 22*(4), 483-506.

Fox, R., Henderson, A., & Malko-Nyhan, K. (2005). They survive despite the organisational culture not because of it – A longitudinal study of new staff perceptions of what constitute support during transition to an acute tertiary facility. *International Journal of Nursing Practice, 11*, 193-199.

Fray, B., & Sherman, R. O. (2017). Best Practices for Nurse Leaders: Succession Planning. *Professional Case Management, 22*(2), 88-94. doi:10.1097/ncm.0000000000000214.

Ganser, T. (2000). An ambitious vision of professional development for teachers. *Bulletin, 84*(618), 6-12. doi: 10.1177/019263650008461802.

Gagliardi, A. R., Webster, F., Perrier, L., Bell, M., & Straus, S. (2014). Exploring mentorship as a strategy to build capacity for knowledge translation research and practice: a scoping systematic review. *Implementation Science, 9*, 122. doi:10.1186/s13012-014-0122-z.

Gold Coast Hospital and Health Service (GCHHS). (2018a). Mentoring Partnership Agreement. Brisbane, QLD: State of Queensland (Queensland Health).

GCHHS. (2018b). Mentoring Toolkit for Mentors. Brisbane, QLD: State of Queensland (Queensland Health).

GCHHS. (n.d.). Mentee Expression of Interest. Brisbane, QLD: State of Queensland (Queensland Health).

Government of Western Australia - Department of Health. (2017). Mentorship. Retrieved from https://ww2.health.wa.gov.au/~/media/Files/Corporate/general%20documents/nursing%20and%20midwifery/PDF/NMO%20Mentor%20Network%20Factsheet%201-%20Introduction%20to%20Mentoring.pdf.

Government of Western Australia - Department of Training and Workforce Development. (n.d.). Talent Management and Succession Planning. Retrieved from https://www.jobsandskills.wa.gov.au/sites/default/files/uploads/documents/EMPLOYERSsection/jswa-emp-talent-management-succession-planning-brochure8.pdf.

Griffith, M. B. (2012). Effective succession planning in nursing: a review of the literature. *Journal of Nursing Management, 20*(7), 900-911.

Groves, K. S. (2007). Integrating leadership development and succession planning best practices. *Journal of Management Development, 26*(3), 239-260.

Hafsteinsdottir, T. B., van der Zwaag, A. M., & Schuurmans, M. J. (2017). Leadership mentoring in nursing research, career development and scholarly productivity: A systematic review. *International Journal of Nursing Studies, 75*, 21-34. doi:10.1016/j.ijnurstu.2017.07.004.

Hansman, C. A. (2016). Mentoring and Informal Learning as Continuing Professional Education. *New Directions for Adult and Continuing Education, 2016*(151), 31-41. doi:10.1002/ace.20193.

Health Workforce Australia. (2012). Health Workforce 2025 - Doctors, Nurses and Midwives - Volume 1. Adelaide, SA: Health Workforce Australia.

Health Workforce Australia. (2014). Australia's Future Health Workforce - Nurses Overview Report. Canberra, ACT: Health Workforce Australia.

Higginbottom, K. (2014). Effective Succession Manegement Results in Improved Employee Engagement. Retrieved from https://www.forbes.com/sites/karenhigginbottom/2014/11/20/successful-succession-management-results-in-improved-employee-engagement/#483b016c12fc.

Hodgson, A. K., & Scanlan, J. M. (2013). A concept analysis of mentoring in nursing leadership. *Open Journal of Nursing, 3*(5), 389.

Huybrecht, S., Loeckx, W., Quaeyhaegens, Y., De Tobel, D., & Mistiaen, W. (2011). Mentoring in nursing education: Perceived characteristics of mentors and the consequences of mentorship. *Nurse Education Today, 31*(3), 274-278. doi:10.1016/j.nedt.2010.10.022.

Jones, B. (2019). Creating a Culture of Promoting From Within. *Dimensions of Critical Care Nursing, 38*(1), 50-53. doi:10.1097/dcc.0000000000000330.

Jones, R. (2015). *The effectiveness of workplace coaching: A meta-analysis of learning and performance outcomes; scale development; theoretical model of individual differences and longitudinal study.* Submitted in fulfilment of the requirement of the degree of Doctor of Philosophy, Business School - Aston University, Birmingham, England. Retrieved from: http://publications.aston.ac.uk/28541/1/JonesRebeccaJ.2016.pdf.

Kallmeyer, R., & Martin, E. (2018). Strategies to Recruit the Next Generation of Nursing Leadership Talent. *Journal of Nursing Administration, 48*(7-8), 368-374. doi:10.1097/nna.0000000000000631.

Lavoie-Tremblay, M., Sanzone, L., Primeau, G., & Lavigne, G. L. (2019). Group mentorship programme for graduating nursing students to facilitate their transition: A pilot study. *Journal of Nursing Management, 27*(1), 66-74. doi:10.1111/jonm.12649.

Leary, J. C., Schainker, E. G., & Leyenaar, J. K. (2016). The Unwritten Rules of Mentorship: Facilitators of and Barriers to Effective Mentorship in Pediatric Hospital Medicine. *Hospital Pediatrics, 6*(4), 219-225. doi:10.1542/hpeds.2015-0108.

Lipscomb, R., & An, S. (2013). Mentoring 101: Building a Mentoring Relationship. *Journal of the Academy of Nutrition and Dietetics, 113*(5), 29-31. doi:10.1016/j.jand.2013.02.010.

Lohrey, J. (2019). Types of Succession Planning. Retrieved from https://smallbusiness.chron.com/types-succession-planning-74776.html.

Lunsford, L. G. (2016). Promoting High Quality Mentoring. *A Handbook for Managing Mentoring Programs* (pp. 40-49). New York: Routledge.

Management Mentors. (2018). Understanding Formal & Informal Mentoring. Retrieved from https://www.management-mentors.com/resources/formal-informal-mentoring.

Manchester Metropolitan University. (n.d.). Mentoring Guidelines. Manchester, UK: Manchester Metropolitan University.

Manning, V., Jones, A., Jones, P., & Fernandez, R. S. (2015). Planning for a smooth transition: evaluation of a succession planning program for prospective nurse unit managers. *Nursing Administration Quaterly, 39*(1), 58-68. doi:10.1097/naq.0000000000000072.

Mariani, B. (2012). The effect of mentoring on career satisfaction of registered nurses and intent to stay in the nursing profession. *Nursing Research and Practice, 2012*(2012), 1-9. doi:10.1155/2012/168278.

Marsh, V. (2015). Mentoring the novice OR nurse. *AORN Journal, 102*(2), 12-13. doi:10.1016/S0001-2092(15)00619-5.

Martin, A. (2015). Talent Management: Preparing a "Ready" agile workforce. *International Journal of Pediatrics and Adolescent Medicine, 2*(3), 112-116. doi:10.1016/j.ijpam.2015.10.002.

McBride, A. B., Campbell, J., Woods, N. F., & Manson, S. M. (2017). Building a mentoring network. *Nursing Outlook, 65*(3), 305-314.

McIlveen, P. (2009). Career development, management, and planning from the vocational psychology perspective. A. Collin & W. Patton (Eds.), *Vocational psychological and organisational perspectives on career: toward a multidisciplinary dialogue* (pp. 63-90). Rotterdam, Netherlands: Sense Publishers.

Medd, W. (2011). Coaching for research in UK higher education institutions: A review. Retrieved from https://www.vitae.ac.uk/vitae-publications/reports/coaching-report-2012-vitae.pdf.

Menges, C. (2016). Toward Improving the Effectiveness of Formal Mentoring Programs: Matching by Personality Matters. *SAGE Journals, 41*(1), 98-129. doi:10.1177/1059601115579567.

Metro North Hospital and Health Service (MNHHS). (2015a). MNHHS Succession Management & Mentoring Framework for Nurses & Midwives. Brisbane, QLD: State of Queensland (Queensland Health).

MNHHS. (2015b). MNHHS Succession Management & Mentoring Toolkit for Nurses & Midwives. Brisbane, QLD: State of Queensland (Queensland Health).

Ministerial Council for Education Early Childhood Development & Youth Affairs (MCEECDYA). (2014). Australian Blueprint for Career Development. Canberra, ACT: Commonwealth of Australia.

Moreno, J. V., & Girard, A. S. (2019). Capitalizing on an Existing Shared Governance Structure in Developing Leadership Succession Planning. *Journal of Nursing Administration, 49*(4), 193-200.

Morgan, A., Cullinane, J. & Pye, M. (2008). Continuing professional development: Rhetoric and practice in the NHS. *Journal of Education and Work, 21*(3), 233-248. doi: 10.1080/13639080802214100.

Morgan, M., & Rochford, S. (2017). Coaching and Mentoring for Frontline Practitioners. Dublin, Irelend: Centre for Effective Services.

National Center for Women & Information Technology. (2011). Evaluating a Mentoring Program: Guide. Retrieved from https://www.ncwit.org/sites/default/files/resources/evaluatingmentoringprogramguideweb.pdf

Northern Alberta Institute of Technology. (2009). Succession Management. Retrieved from https://www.nait.ca/portal/server.pt/document/10799/Succession+Management+Process+-+updated+April+16%2C+2009.

Nova Scotia Public Service Commission. (2015). Mentoring Program Guide. Retrieved from http://novascotia.ca/psc/pdf/employeeCentre/training/mentoring/iNSpireMentorshipProgramGuide.pdf.

Nowell, L., Norris, J. M., Mrklas, K., & White, D. E. (2017). A literature review of mentorship programs in academic nursing. *Journal of Professional Nursing, 33*(5), 334-344. doi:10.1016/j.profnurs.2017.02.007.

Nurses and Midwives [Queensland Health] Award – State 2015 [2018 Stage Wage Case Reprint], 2018). Brisbane, QLD: Queensland Industrial Relations Commission. Retrieved from https://www.qirc.qld.gov.au/sites/default/files/nurses_and_midwives_swc18.pdf?v=1542538772.

Nursing and Midwifery Board of Australia (NMBA). (2013). A national framework for the development of decision-making tools for nursing and midwifery practice. Melbourne, VIC: NMBA.

NMBA. (2016). Continuing Professional Development Registration Standard. Melbourne, VIC: NMBA.

Pedersen, A., Sorensen, J., Babcock, T., Bradley, M., Donaldson, N., Donnelly, J. E., & Edgar, W. (2018). A Nursing Leadership Immersion Program: Succession Planning Using Social Capital. *Journal of Nursing Administration, 48*(3), 168-174. doi:10.1097/nna.0000000000000592.

Phillips, T., Evans, J. L., Tooley, S., & Shirey, M. R. (2018). Nurse manager succession planning: A cost-benefit analysis. *Journal of Nursing Management, 26*(2), 238-243. doi:10.1111/jonm.12512.

Planning Institute Australia. (n.d.). Mentoring Program Handbook for Mentees and Mentors. Retrieved from https://www.planning.org.au/documents/item/8391.

Queensland Health. (2010). Queensland Health Preceptor Program. Brisbane, QLD: State of Queensland (Queensland Health).

Queensland Health. (2011). Building Blocks of Lifelong Learning: A Framework for nurses and Midwives in Queensland. Brisbane, QLD: State of Queensland (Queensland Health).

Queensland Health. (2018a). Framework for Lifelong Learning for Nurses and Midwives (Queensland Health), June 2018. Brisbane, QLD: State of Queensland (Queensland Health).

Queensland Health. (2018b). Human Resource Policy G6 (QH-POL-183): Orientation, induction and mandatory training. Brisbane, QLD: State of Queensland (Queensland Health).

Queensland Health. (n.d.). Nursing and Midwifery Career Pathways Factsheet. Brisbane, QLD: State of Queensland (Queensland Health).

Ramseur, P., Fuchs, M. A., Edwards, P., & Humphreys, J. (2018). The Implementation of a Structured Nursing Leadership Development Program for Succession Planning in a Health System. *Journal of Nursing Administration, 48*(1), 25-30. doi:10.1097/nna.0000000000000566.

Rothwell, W. J. (2010). *Effective Succession Planning - Ensuring leadership continuity and building talent from within* (4th ed.). New York: AMACOM – American Management Association.

Royal Children's Hospital (RCH). (2015). Formal Mentoring: A Guide for Nurses at the RCH. Retrieved from https://www.rch.org.au/uploadedFiles/Main/Content/nursingresearch/Mentoring%20Guide%20Draft%20May%202015.pdf.

Saba. (2019). Creating Talent Pools. Retrieved from https://www.saba.com/au/resources/how-tos/creating-talent-pools.

Scottish Social Services Council. (SSSC). (2014). Mentoring: Supporting and Promoting Professional Development and Learning. United Kingdom: Scottish Social Services Council.

Sibbald, S. L., Wathen, C. N., & Kothari, A. (2017). Managing Knowledge in Transitions: Experiences of Health Care Leaders in Succession Planning. *Health Care Manager, 36*(3), 231-237. doi:10.1097/hcm.0000000000000167.

Sinclair, P., Pich, J., Hennessy, M., Wooding, J., Williams, J., Young, S., & Schoch, M. (2015). Mentorship in the health disciplines. *Renal Society of Australasia Journal, 11*(1), 41-46.

Smith, S. K., Hecker-Fernandes, J. R., Zorn, C., & Duffy, L. (2012). Precepting and mentoring needs of nursing faculty and clinical instructors: Fostering career development and community. *Journal of Nursing Education, 51*(9), 497-503.

Spacey, J. (2017). 8 Types of Organizational Knowledge. Retrieved from https://simplicable.com/new/organizational-knowledge.

Stewart-Lord, A., Baillie, L., & Woods, S. (2017). Health care staff perceptions of a coaching and mentoring programme: A qualitative case study evaluation. *International Journal of Evidence Based Coaching and Mentoring, 15*(2), 70-85. doi:10.24384/000251.

Stone, D. L., & Deadrick, D. L. (2015). Challenges and opportunities affecting the future of human resource management. *Human Resource Management Review, 25*(2), 139-145. doi:10.1016/j.hrmr.2015.01.003.

Sunshine Coast Hospital and Health Service (SCHHS). (2016). Mentoring/Succession Planning Tools. Sunshine Coast, QLD: State of Queensland (Queensland Health).

SCHHS. (2018). Clinical Coach Mentor Program. Sunshine Coast, QLD: State of Queensland (Queensland Health).

SCHHS. (n.d.-a). Clinical Coach Mentor Framework. Sunshine Coast, QLD: State of Queensland (Queensland Health).

SCHHS. (n.d.-b). Mentor, Mentee Roles and Responsibilities. Sunshine Coast, QLD: State of Queensland (Queensland Health).

Talent Guard. (2018). Building An Organizational Talent Pool To Support Your Succession Planning. Retrieved from https://talentguard.com/building-an-organizational-talent-pool-to-support-your-succession-planning.

Tiew, L. H., Koh, C. S. L., Creedy, D. K., & Tam, W. S. W. (2017). Graduate nurses' evaluation of mentorship: Development of a new tool. *Nurse Education Today, 54*, 77-82. doi:10.1016/j.nedt.2017.04.016.

Titzer, J. L., Phillips, T., Tooley, S., Hall, N., & Shirey, M. (2013). Nurse manager succession planning: synthesis of the evidence. *Journal of Nursing Management, 21*(7), 971-979. doi:10.1111/jonm.12179.

Titzer, J. L., & Shirey, M. R. (2013). Nurse manager succession planning: a concept analysis. *Nursing Forum, 48*(3), 155-164. doi:10.1111/nuf.12024.

Titzer, J. L., Shirey, M. R., & Hauck, S. (2014). A nurse manager succession planning model with associated empirical outcomes. *Journal of Nursing Administration, 44*(1), 37-46. doi:10.1097/nna.0000000000000019.

Tonna, M. A., Bjerkholt, E., & Holland, E. (2017). Teacher mentoring and the reflective practitioner approach. *International Journal of Mentoring and Coaching in Education, 6*(3), 210-227. doi:10.1108/IJMCE-04-2017-0032.

Treasury Board of Canada. (2012). Succession Planning and Management Guide. Retrieved from https://www.tbs-sct.gc.ca/gui/spgr/spg-gpgr-eng.asp?for=hrps.

Trede, F., Sutton, K., & Bernoth, M. (2015). Conceptualisations and perceptions of the nurse preceptor's role: A scoping review. *Nurse Education Today, 36*, 268-274.

Trepanier, S., & Crenshaw, J. T. (2013). Succession planning: a call to action for nurse executives. *Journal of Nursing Management, 21*(7), 980-985. doi:10.1111/jonm.12177.

United States Office of Personnel Management. (2009). A Guide to the Strategic Leadership Succession Management Model. Retrieved from http://www.opm.gov/hcaafresourcecenter/assets/LeadGuide.pdf.

University of Illinois at Chicago. (n.d.). Mentoring Best Practices - Managing Challenges. Retrieved from https://www.ccts.uic.edu/sites/default/files/uploads/MentoringBestPracticesManagingChallenges.pdf.

University of New South Wales (UNSW). (2015). Academic Mentoring Program. Kensington, NSW: UNSW.

University of Washington. (n.d.). Quick Reference for Existing or Potential Mentors at the UW. Retrieved from https://hr.uw.edu/pod/wp-content/uploads/sites/10/2017/04/Quick-Reference-for-Mentors.pdf.

Valentin-Welch, M. (2016). Evaluation of a National E-Mentoring Program for Ethnically Diverse Student Nurse-Midwives and Student Midwives. *Journal of Midwifery & Women's Health, 61*(6), 759-767. doi:10.1111/jmwh.12547.

Valizadeh, S., Borimnejad, L., Rahmani, A., Gholizadeh, L., & Shabazi, S. (2016). Challenges of the preceptors working with new nurses: A phenomenological research study. *Nurse Education Today, 44*(9), 92-97.

Vanvactor, J. D. (2015). Healthcare succession management: are we ready? *International Journal of Public Leadership, 11*(2), 107-122. doi:10.1108/IJPL-11-2014-0021.

Verret, G., & Lin, V. (2016). Easing the Transition: An Innovative Generational Approach to Peer Mentoring for New Graduate Nurses. *Journal of Pediatric Nursing, 31*(6), 745-756. doi:10.1016/j.pedn.2016.08.003.

Victorian Public Sector Commission. (2015). Great managers, great results: Development framework for Victorian Public Sector Managers. Melbourne, VIC: Victorian State Government.

Vinales, J. J. (2015). The mentor as a role model and the importance of belongingness. *British Journal of Nursing, 24*(10), 532-535. doi:10.12968/bjon.2015.24.10.532.

Warshawsky, N., & Martin, E. (2017). Guiding Principles for Creating Value and Meaning for the Next Generation of Nurse Leaders. *Journal of Nursing Administration, 47*(9), 418-420. doi:10.1097/nna.0000000000000507.

Webb, T., Diamond-Wells, T., & Jeffs, D. (2017). Career Mapping for Professional Development and Succession Planning. *Journal for Nurses in Professional Development, 33*(1), 25-32. doi:10.1097/nnd.0000000000000317.

West, M., Smithgall, L., Rosler, G., & Winn, E. (2016). Evaluation of a nurse leadership development programme. *Nursing Management, 22*(10), 26-31. doi:10.7748/nm.22.10.26.s29.

White, D. E., Nowell, L., Benzies, K., & Rosenau, P. (2017). Factors that impact implementation of mentorship programs in nursing academia: A sequential-explanatory mixed methods study. *Journal of Nursing Education and Practice, 7*(10), 1-11. doi:10.5430/jnep.v7n10p1.

Whitehead, B., Owen, P., Henshaw, L., Beddingham, E., & Simmons, M. (2015). Supporting newly qualified nurse transition: A case study in a UK hospital. *Nurse Education Today, 36*(1), 58-63.

Zhang, Y., Qian, Y., Wu, J., Wen, F., & Zhang, Y. (2016). The effectiveness and implementation of mentoring program for newly graduated nurses: A systematic review. *Nurse Education Today, 37*, 136-144. doi:10.1016/j.nedt.2015.11.027.

This page has been left intentionally blank

Queensland Government

Clinical Supervision Framework for Queensland Nurses & Midwives

Professional Boundaries

Standards

Development

Confidential

Relationships

Quality of Care

Reflective

Education

Choice

Wellbeing

Safe

Support

Trusting

Communication

March 2021

Queensland Government

Clinical Supervision Framework for Queensland Nurses and Midwives

Published by the State of Queensland (Queensland Health), March 2021

For more information contact:
Office of the Chief Nursing and Midwifery Officer, Clinical Excellence division, Department of Health, GPO Box 48, Brisbane QLD 4001, email chiefnurse-office@health.qld.gov.au.

An electronic version of this document is available at:
www.qheps.health.qld.gov.au/nmoq/professional-capability

Foreword by the Office of the Chief Nursing and Midwifery Officer

Nurses and midwives undertake a unique role within our healthcare teams. They provide the foundation and core of service delivery in all settings across our state. In our constantly evolving healthcare system, we are facing increasingly more complex and unique challenges in the workplace. While the work of nurses and midwives is often rewarding, it can also be mentally, emotionally and physically challenging. We care for people across all stages of their lives, focused on the biopsychosocial needs of communities. We hear stories, we hold hope and we care for individuals, groups, their families and communities as effectively as we can. We use critical thinking and high-level analysis and technical skills in every aspect of care that we deliver. There has never been a more important time to acknowledge nurses' and midwives' valuable role as independent and collaborative caregivers, as well as to recognise the support that clinical supervision provides to us and the people that we care for.

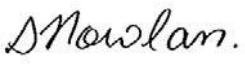
In 2019, the Australian College of Midwives, Australian College of Nurses and Australian College of Mental Health Nurses published the Joint Position Statement Clinical Supervision for Nurses & Midwives, which formally recognised the value of clinical supervision for all nurses and midwives in Australia. Following this important piece of work, the Office of the Chief Nursing and Midwifery Officer (OCNMO) is pleased to announce the publication of the Clinical Supervision Framework for Queensland Nurses and Midwives.

Clinical supervision is an important professional development activity that benefits nurses and midwives, the people we care for and the organisations in which we work. It is becoming increasingly recognised as a core component of contemporary nursing and midwifery practice. Additionally, it supports reflective practice approaches that align with an important way to manage health and wellbeing.

At its heart, clinical supervision is a confidential, supportive and culturally safe activity that enables nurses and midwives to critically reflect on their practice, while contributing to overall wellbeing and the provision of quality care. Nursing and midwifery wellbeing is essential to optimal care delivery, as well as to nursing and midwifery recruitment, retention and the sustainable future of our professions.

The Clinical Supervision Framework for Queensland Nurses and Midwives was developed in consultation with representatives from each hospital and health service and has the support of nursing and midwifery leaders from across Queensland. I would encourage all nurses and midwives to use this framework, and the accompanying resources, to support the implementation of clinical supervision programs within your teams, workplaces and organisations.

While it will take time to build clinical supervision capability across Queensland, the publication of this framework is an important milestone, and it heralds an exciting time for nurses and midwives in Queensland. I encourage the uptake of this framework to all nurses and midwives and acknowledge this framework supports your valuable and significant contributions to our healthcare systems and community care.



Adjunct Professor Shelley Nowlan *RN Bn MHM G.DipPM GCert.PA FACN GAICD*

Chief Nursing and Midwifery Officer

Authors

Kobie Hatch — Project Manager (Nurse Educator), Nursing and Midwifery Education and Workforce, Office of the Executive Director Nursing and Midwifery Metro North Hospital and Health Service (MNHHS)

Cathy Boyle — Project Officer (Nurse Educator), Nursing and Midwifery Education and Workforce, Office of the Executive Director Nursing and Midwifery Metro North Hospital and Health Service (MNHHS)

Acknowledgements

The authors of this version of the *Clinical Supervision Framework for Queensland Nurses and Midwives* wish to acknowledge:

- project sponsor and executive leadership provided by Adjunct Professor Alanna Geary, Executive Director Nursing & Midwifery, Metro North Hospital and Health Service
- sponsorship and professional support provided by the Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division – Department of Health:
  - Shelley Nowlan, Chief Nursing and Midwifery Officer, Queensland Health
  - Michelle Gunn, Director of Nursing, Professional Capability, Office of the Chief Nursing and Midwifery Officer, Clinical Excellence Division
- project oversight, leadership and support provided by Metro North Hospital and Health Service Nursing & Midwifery leaders:
  - Robyn Fox, Professor of Nursing and Midwifery Professional Education and Workforce Development, Office of the Executive Director Nursing and Midwifery MNHHS
  - Lisa Fawcett, Director of Nursing/Operations Director/MHRT Member, Metro North Mental Health, MNHHS
  - Nathan Dart, Nursing Director, Metro North Mental Health, MNHHS
  - Christine Burridge, Nursing & Midwifery Director, Education, Office of the Executive Director Nursing and Midwifery MNHHS
- Metro North Mental Health Service for the provision of existing resources that have been used to support the development of the framework
- specialist subject matter contributions by:
  - Gerry Mullan, Nurse Educator, Mental Health, The Prince Charles Hospital, MNHHS
  - Joan Holmes, Nurse Educator, Internal Medicine Services, The Prince Charles Hospital, MNHHS
  - Chris Dawber, Clinical Nurse Consultant, Consultation Liaison Psychiatry, Sunshine Coast University Hospital, SCHHS
- editorial acknowledgement:
  - Nursing Director Education Forum members for advice, feedback, editorial review and endorsement
  - Allison Bowen, Nursing Director Education, MNHHS for editorial review
- specialist diagrammatical contributions by:
  - Tegan Louttit, Clinical Nurse Consultant, Metro North Mental Health, MNHHS.

Editorial Acknowledgements:

Cairns and Hinterland Hospital and Health Service

- Kylie Dunbar-Reid – Nursing Director Education and Research

Central Queensland Hospital and Health Service

- Julie Kahl – Nursing Director Education and Research, Rockhampton Hospital

Central West Hospital and Health Service

- Danielle Causer – Executive Director Nursing & Midwifery Services

Children's Health Queensland Hospital and Health Service

- Kim Anderson – Nursing Director Learning and Workforce Development, Queensland Children's Hospital

Darling Downs Hospital and Health Service

- Helen Towler – Nursing Director
- Carolyn Bourke – Acting Nursing Director Education and Research

Gold Coast Hospital and Health Service

- Lyn Armit – Director of Nursing Education and Research

Mackay Hospital and Health Service

- Karen Wade – Nursing Director Education and Research, Mackay Base Hospital

Metro North Hospital and Health Service

- Robyn Fox – Professor of Nursing and Professional Education and Workforce Development

Metro South Hospital and Health Service

- Bernadette Thomson – Nursing Director Education, Princess Alexandra Hospital

North West Hospital and Health Service

- Julie Parry – Nursing Director Professional Practice Support Unit

Sunshine Coast Hospital and Health Service

- Annette Faithfull-Byrne – Nursing Director Education Staff Development and Research, Sunshine Coast University Hospital

South West Hospital and Health Service

- Leanne Raatz – Nursing Director Education

Torres and Cape Hospital and Health Service

- Sarah Worth – Director of Nursing Clinical Education and Practice Development

Townsville Hospital and Health Service

- Debbie Maclean – Nursing Director Education and Research

West Moreton Hospital and Health Service

- Ruth McCaffery – Nursing Director, Education and Research, Ipswich Hospital

Wide Bay Hospital and Health Service

- Cheryl Steers – Nursing Director Education, Bundaberg Hospital

Table of Contents

1. Intent 8
2. Glossary 8
3. Assumptions 8
4. Applicability 9
5. Clinical supervision in context 9
6. Principles of clinical supervision 10
7. Functions and benefits of clinical supervision 11

The restorative function 11
The normative function 11
The formative function 11
Benefits of clinical supervision 11

8. Governance of clinical supervision 11

Clinical supervisor preparation, education, training and competence 12
Clinical supervisee education 12
Clinical supervision coordinator 12
Documentation 12
Managing issues 13
Supervision of Supervision 13
Dual relationships 13
Evaluation 13

9. Key elements of clinical supervision 13

Clinical supervisory relationship 13
Choice 14
Confidentiality 14

10. Formats 19

Group clinical supervision 19

11. Implementation and sustainability of clinical supervision 21

Implementation planning 21
Effective implementation and sustainability 21

12. Clinical supervision evaluation 21
Informal evaluation 22
Formal evaluation 22
13. Conclusion 22
Appendix 1: Glossary 23
Appendix 2: Clinical supervision factsheets 25
2.1 What to expect in a preliminary clinical supervision session—a fact sheet for supervisees 25
2.2 Clinical supervision—FAQs 27
2.3 Line manager—FAQs 30
2.4 Clinical supervision implementation factsheet 32
Appendix 3: Clinical supervision resources 35
3.1 Sample individual Clinical Supervision Working Agreement/Contract 35
3.2 Sample group Clinical Supervision Working Agreement/Contract 36
3.4 Clinical supervision process flowchart 39
3.5 Diagrammatical representation of clinical supervision framework 40
References 44

1. Intent

While the work of nurses/midwives in contemporary healthcare settings can bring considerable rewards, it can also be challenging and emotionally burdensome. Clinical supervision provides a forum for all nurses/midwives to receive support and maintain psychological wellness (Butterworth, Bell, Jackson, & Pajnkar, 2008; Cutcliffe, Sloan, & Bashaw, 2018; Love, Sidebotham, Fenwick, Harvey, & Fairbrother, 2017; Pollock et al., 2017) while promoting reflective practice, critical thinking and ongoing professional development. (Australian College of Midwives, Australian College of Nursing, & The Australian College of Mental Health Nurses inc., 2019b).

The primary focus of the Clinical Supervision Framework for Queensland Nurses and Midwives is to:

- support a shared understanding of the key principles of clinical supervision, along with definitions of what it is and what it is not
- support the development and maintenance of quality clinical supervision programs in the workplace by outlining key responsibilities of the clinical supervisor, clinical supervisee and the organisation
- provide a suite of resources that can be used by hospital and health services to support the implementation, monitoring and evaluation of clinical supervision.

2. Glossary

In 2019, the Australian College of Midwives, Australian College of Nursing and the Australian College of Mental Health Nurses Inc. released a Joint Position Statement on Clinical Supervision for Nurses and Midwives that recommends clinical supervision for all nurses and midwives.

This document defines clinical supervision as *'a formally structured professional arrangement between a supervisor and one or more supervisees'. It is a purposely constructed regular meeting that provides for critical reflection on the work issues brought to that space by the supervisee(s); it is a confidential relationship within the ethical and legal parameters of practice. Clinical supervision facilitates development of reflective practice and the professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace.'* (p.2).

The term 'clinical supervision' has attracted several other meanings and applications in healthcare, and this has been identified as problematic when used across different contexts (Australian Clinical Supervision Association, 2015; Australian College of Midwives, Australian College of Nursing, & The Australian College of Mental Health Nurses inc., 2019a; Martin, Kumar, & Lizarondo, 2017).

For the purposes of this document, clinical supervision does not refer to the direct or indirect supervision of a student or a colleague's work practice (including observational assessment), nor does it refer to managerial supervision or mentorship (Australian College of Midwives et al., 2019a; Martin et al., 2017; HETI, 2013).

A glossary has been provided to clarify terms used in this document.

3. Assumptions

The following assumptions have been made in relation to the development and use of this document:

- The Hospital and Health Service (HHS)/facility/directorate/service promotes a culture of lifelong learning that aligns with Section 12.3 of the *Framework for Lifelong Learning for Nurses and Midwives Queensland Health - June 2018: Supporting Relationships to Build Capacity: Clinical Supervision* (Queensland Health, 2018a, p. 54).
- The HHS/facility/directorate/service values a sustainable, competent, compassionate, innovative, professional and capable person-centered nursing/midwifery workforce that is encouraged to participate in ongoing self-reflection and continuous learning (Queensland Health, 2018a, p. 8).
- Each nurse/midwife assumes personal accountability and responsibility for professional engagement, their lifelong learning pathway and effective utilisation of professional development opportunities (Queensland Health, 2018a, p. 8).
- The workplace environment supports a culture that fosters the development of nursing/midwifery staff, and lifelong learning that meets clinical, professional and organisational needs (Queensland Health, 2018a, p. 8).

4. Applicability

The Clinical Supervision Framework for Queensland Nurses and Midwives is applicable to all nursing/midwifery groups and individuals.

The *Position Statement: Clinical Supervision for Nurses and Midwives* (ACM et al., 2019) recommends clinical supervision for all nurses/midwives, regardless of their role, area of practice or years of experience. This includes nurses/midwives who do not provide direct clinical care.

Clinical supervision may occur between members of different professions. It may also be provided by staff who are not employed by Queensland Health (external clinical supervision). This document is applicable in both of these circumstances.

5. Clinical supervision in context

Clinical supervision is one of the many supportive professional development activities within nursing/midwifery practice that support nurses/midwives to maintain their knowledge, skills and competence in their professional roles (refer Diagram 1).

While clinical supervision is identified as a discreet mechanism to the other activities identified in Diagram 1, it should be noted that 'reflective practice' and structured 'peer supervision' may also meet the criteria for clinical supervision in some circumstances.

Diagram 1: Supportive Professional Development Activities

Adapted from the Clinical Supervision Guidelines for Mental Health Services (Queensland Health, 2009, p.10)

Table 1: What clinical supervision is and what it is not

What clinical supervision is	What clinical supervision is not
Regular (minimum one hour per month)	Debriefing or a one-off session
Voluntary	Enforced
Confidential (within the agreed limits of confidentiality)	A method of surveillance
Clinician-led. The clinician chooses their clinical supervisor and determines the focus for each session.	Directed learning where the supervisor sets the agenda
Conducted in protected time, away from the practice setting	Counselling or a form of therapy
Focused on the person receiving care, addressing issues of clinical practice and care delivery	Focused on personal issues not related to the workplace
Provided by a clinician who has received education and training in clinical supervision	Provided by line managers or used to address performance-related or managerial issues
A formal, ongoing relationship based on a negotiated agreement	A form of 'on the job' preceptorship or mentoring
Intra-professional (conducted by member of the same profession) or cross-professional (conducted by a member of another profession)	Hierarchical
A process that exists for the purposes of reducing the emotional burden of the work that nurses and midwives do, facilitating professional development and maintaining professional standards	The direct or indirect supervision, monitoring or oversight of a student or a colleague's work practice
A culturally safe and respectful relationship	
Supported by an agreement, referred to as the clinical supervision working agreement (CSWA)	

Adapted from Australian Clinical Supervision Association (2015); Department of Health and Human Services (2018); Queensland Health (2009)

6. Principles of clinical supervision

Clinical supervision:

- should be available to all nurses and midwives regardless of their level or role
- requires a trusting alliance between the clinical supervisor and supervisee(s)
- provides a safe and confidential space for nurses and midwives to critically reflect on their practice
- is a supportive, culturally safe process that contributes to the health and wellbeing of nurses and midwives.

Adapted from Australian College of Midwives et al. (2019a).

7. Functions and benefits of clinical supervision

Effective clinical supervision requires three main functions: restorative, normative and formative (Bond & Holland, 2010; Cutcliffe, Butterworth, & Proctor, 2001).

The restorative function

Nurses/midwives can be affected by the distress and pain of the people that they care for, and they need the appropriate time and space to be able to acknowledge and reflect on the impact that this has on them (Bond & Holland, 2010). Clinical supervision provides this opportunity and has a support and healing component, which provides restoration for the nurse/midwife and helps reduce the emotional burden that is inherent to the role (Begat, Ellefsen, & Severinsson, 2005, Driscoll, Stacey, Harrison Dening, Boyd, & Shaw, 2019; Love, 2017).

Through this work, the nurse/midwife gains insights into their relationship with the person that they care for. The goal is to assist the supervisee to understand the person's presentation, to see them as an individual and to explore any predetermined ideas, blind spots and assumptions (Hawkins & Shohet, 2012).

The normative function

The normative function of clinical supervision supports safe and ethical practice by focusing on competence, accountability and adherence to clinical, organisational and professional standards (Bond & Holland, 2010). It provides the supervisee with an opportunity to examine their values and to be guided through the ethical dilemmas of their practice.

The formative function

Clinical supervision provides the opportunity for learning, development and the strengthening of practice, and aligns with the *Framework for Lifelong Learning for Nurses and Midwives* (Queensland Health, 2018a). It provides an opportunity for nurses and midwives to reflect on their practice and then identify and develop the knowledge and skills required to improve their practice (Bond & Holland, 2010; Proctor, 2011).

Benefits of clinical supervision

Clinical supervision has been shown to contribute to positive outcomes across several domains, aligning to the functions outlined in the previous section.

The clinical supervision process promotes self-evaluation and critical thinking by the clinician (Australian College of Midwives et al., 2019a), which, in turn, can improve the relationships with the people that nurses and midwives care for and the quality of care provided (Hawkins & Shohet, 2012).

<u>Benefits to nurse/midwife clinical practice:</u>

- provides valuable support for junior/graduate nursing staff in the early years of practice (Cummins, 2009)
- maintains professional boundaries (Pettman, Loft, & Terry, 2019)
- supports midwives to find their own solutions and answers to practice issues (Love, 2017).

<u>Benefits to nurse/midwife wellbeing:</u>

- nurses who attend clinical supervision are found to experience 'less physical symptoms, reduced anxiety and fewer feelings of not being in control' (Bégat, et al., p. 229)
- decrease in occupational stress and burnout (Butterworth, Carson, & White,1997 in Hall, 2018; Driscoll 2007 in Love, 2017, p.272, O'Connell, et al., 2011).

<u>Outcomes for people receiving care:</u>

- improved outcomes and satisfaction for patients and clients (Bambling, King, Schweitzer, & Raue P, 2006; White & Winstanley, 2010).

<u>Benefits to the organisation:</u>

- improved graduate nurse staff retention (Cummins, 2009)
- lower prevalence of sick leave (Ashburner, Meyer, Cotter, Young, & Ansell, 2004)
- improved aspects of team functioning, such as communication and cohesion (Dawber, 2013).

8. Governance of clinical supervision

Appropriate governance systems are essential to ensure safety, transparency and accountability of clinical supervision in the workplace. The development

of policies/procedures that articulate the rights and responsibilities of the clinical supervisor, clinical supervisee and the organisation are required. It is also recommended that organisations identify a clinical supervision coordinator to act as a key contact person for the clinical supervision program.

Clinical supervisor preparation, education, training and competence

All clinical supervisors must undertake appropriate and specific education and training in clinical supervision, prior to commencing the role (Queensland Health, 2009). Without suitable training, the clinical supervision delivered may be insufficient and may even be damaging—having the opposite desired effect (Beddoe, 2017).

Further, supervisees will then base the future of their clinical supervision practice on their own experiences, becoming ineffective clinical supervisors themselves (Barnett & Molzon, 2014).

Clinical supervisors should demonstrate warmth, openness, curiosity, and a supportive and engaging manner. They should be a willing listener (Puffett, 2017), reliable, trustworthy, self-reflective and appreciative of feedback (Queensland Health, 2009).

Clinical supervisors should meet the following eligibility criteria for training:

- a preference of five or more years of experience in clinical practice
- demonstrated skills and attributes, as noted above
- current participation in own clinical supervision, preferably for 12 months or longer
- line manager and clinical supervisor endorsement to train as a clinical supervisor.

Training courses vary in length. A minimum of three days (or equivalent) initial training is required, with completion of a one-day refresher course recommended every three years (Queensland Health, 2018b).

Clinical supervisors are also required to engage in their own regular clinical supervision and supervision of supervision (SOS), as outlined on p.13.

It is recommended that organisations include these requirements in their local guidelines/procedures and support clinical supervisors to maintain their professional development within the clinical supervision specialty.

Clinical supervisee education

Clinical supervisees require orientation to local clinical supervision processes. Being a supervisee is an active process (Hawkins & Shohet, 2012) and, therefore, supervisees should accept responsibility for, and receive education on, their role as a supervisee, to assist them in gaining the most benefit from the process (Australian College of Midwives et al., 2019b; Colthart et al., 2018; Lynch & Happell, 2008b).

Part of the preparation for supervisees is to appreciate the need to arrive ready and prepared for clinical supervision. This may include keeping a log of clinical issues and scenarios for discussion. Supervisees should also identify their learning needs and be willing to both accept and provide feedback (Proctor, 2011).

Clinical supervision coordinator

The clinical supervision coordinator is a nominated role that assists the organisation to maintain governance over the clinical supervision program by:

- providing a central point of contact for clinical supervision
- working with the leadership team to monitor, develop and support the clinical supervision program
- maintaining a list of trained clinical supervisors in the workplace
- providing support to line managers, clinical supervisors and supervisees as required.

Documentation

The minimum standard for documentation includes a clinical supervision working agreement (CSWA) and a record of attendance at each session (Queensland Health, 2009).

These records should be kept by both the clinical supervisor and the supervisee, and a copy may be requested by the organisation for data collection and/or reporting purposes.

In addition to this, clinical supervisors and supervisees may negotiate additional record keeping for professional development, memory recall or other purposes. Storage of such records should be negotiated and should generally remain with the nurse/midwife for confidential filing (Queensland

Health, 2009).

Managing issues

If issues arise in the clinical supervisory relationship, they should be addressed by the clinical supervisor and supervisee(s) within clinical supervision in the first instance. If issues are unable to be resolved at this level, they should be escalated via the clinical supervisors' or supervisees' line manager or as per local processes.

In the event of a breach of legislation, ethical or professional guidelines or issues requiring mandatory reporting, the clinical supervisor and supervisee must comply with national, state, Queensland Health and local reporting and documentation requirements.

Supervision of Supervision

Supervision of Supervision (SOS) is an essential requirement for all clinical supervisors. It's purpose is to assist clinical supervisor development (Hawkins & Shohet, 2012). SOS allows the clinical supervisor to examine their clinical supervision practice and how it impacts the clinical supervision process.

It is recommended that novice clinical supervisors receive one hour of SOS for every five hours of clinical supervision practice (Hawkins & Shohet, 2012). This provides support for the new clinical supervisor and, as experience increases, SOS may be incorporated into their regular clinical supervision (as long as it is still addressed).

Organisations can build SOS capacity by identifying and supporting experienced clinical supervisors (who are well supported through their own clinical supervision and other professional development activites) to provide SOS to other nurses/midwives.

Dual relationships

The divergent expectations that are inherent in different roles (such as line manager, friend, close colleague and clinical supervisor) are difficult to manage and should be avoided wherever possible (Australian Clinical Supervision Association, 2015; Scaife, 2001).

Clinical supervision is not line management supervision and should not be used to address performance-related or managerial issues. Clinical supervisors should not be consulted or involved in any performance management issues relating to their supervisee(s). This also includes any assessment of clinical competence or capability.

Evaluation

Clinical supervision should be periodically evaluated to ensure it is meeting the expectations and goals set in the initial CSWA. There are a number of tools specifically designed to assess therapeutic alliance, quality of clinical supervision and outcomes, as outlined in section 12 of this document.

9. Key elements of clinical supervision

Clinical supervisory relationship

The alliance between the clinical supervisor and the supervisee(s) is the central element of effective clinical supervision (Australian College of Midwives et al., 2019b).

This trusting alliance, often referred to as the 'supervisory alliance' or 'working alliance', has three essential components: the bond, task and goal (Bordin, 1983).

The *bond* focuses on how the clinical supervision relationship is developed and maintained. The *task* refers to the critical thinking, reasoning and actions taken to achieve the *goals* that are mutually agreed between the clinical supervisor and the nurse/midwife. Effective clinical supervision requires all three of these elements to achieve its purpose.

To develop and maintain this alliance, clinical supervision:

- is conducted in regular, private and protected time, away from the practice setting
- has effective communication and feedback at its core, is supportive, facilitative and focused on the work issues brought to the session by the supervisee(s)
- is an opportunity to talk about the realities, challenges and rewards of practice and to be attentively heard and understood by another professional
- facilitates supervisee self-monitoring and self-accountability and involves the supervisee learning to be a reflective practitioner

- is predictable and consistent with thoughtful and clear structures, boundaries, processes and goals
- develops knowledge and confidence with a strengths-focus, aimed at building supervisee practice skills and awareness of practice
- is a culturally safe and respectful relationship that has commitment from both the supervisor and supervisee(s)
- is supported by an agreement that is reviewed regularly and includes the extent and limits of confidentiality
- is confidential, within the ethical and legal boundaries of nursing and midwifery practice
- supports supervisees to choose their supervisors
- is provided by professionals who have undertaken specific training in clinical supervision and engage in their own regular clinical supervision
- is not provided by a professional who has organisational responsibility to direct, coordinate or evaluate the performance of the supervisee(s).

(Australian College of Midwives et al., 2019b, p. 2)

Choice

Clinical supervision is a voluntary professional development activity. Clinicians have the choice to participate (or not) in clinical supervision, whether they are a clinical supervisor or a supervisee.

Supervisees should be supported to choose their clinical supervisors and have a choice to participate in individual and/or group clinical supervision where available.

Some staff may choose to access clinical supervision from an external provider. In these cases, the same principles and processes apply.

Confidentiality

Confidentiality in clinical supervision is ensured except in circumstances where there is:

- a breach of the code of conduct of the organisation
- a breach of professional code of ethics
- a breach of duty of care
- concern about the safety of a clinician or consumer
- issues identified that are subject to mandatory reporting.

While the content of clinical supervision is confidential (subject to the above-mentioned exceptions), engagement in clinical supervision is not confidential.

Table 2: Responsibilities of supervisee, supervisor and the organisation

Element	Supervisee	Clinical Supervisor	Organisation
Education and training	To attend/complete appropriate education to have the relevant understanding to be able to participate in clinical supervision (Australian College of Midwives et al., 2019b; Colthart et al., 2018)	To complete appropriate clinical supervisor education and training and maintain ongoing professional development in the role (Australian College of Midwives et al., 2019b)	To provide staff with information on accessing clinical supervision in the workplace. To identify and then support clinical supervisors to attend appropriate education, training and ongoing professional development for the role.
Documentation	To maintain a minimum record of: • the CSWA • when clinical supervision has taken place, or been cancelled To agree on record keeping arrangements with your clinical supervisor (Queensland Health, 2009).	To maintain a minimum record of: • the CSWA • when clinical supervision has taken place, or been cancelled To agree on record keeping arrangements with your supervisee (Queensland Health, 2009).	To store all clinical supervision records securely
Dual relationships	To choose a clinical supervisor who is not a friend, colleague or team member (Australian clinical supervision Association, 2015; Australian College of Midwives et al., 2019b).	To decline requests to supervise friends, colleagues or people that you line manage or have a dual relationship with. To decline requests for a managerial or educational assessment within the clinical supervisory relationship. To manage any dual relationships effectively, should they occur (Australian clinical supervision Association, 2015; Queensland Health, 2009; Scaife, 2001).	To actively honour the clinical supervisory relationship by discouraging dual relationships wherever possible (Australian clinical supervision Association, 2015; Australian College of Midwives et al., 2019b; Queensland Health, 2009).

Element	Supervisee	Clinical Supervisor	Organisation
Boundaries	To be accountable for appropriately addressing any issues that are outside the clinical supervision scope, and to seek appropriate assistance for these.	To set personal limits and professional boundaries on what issues are discussed during clinical supervision. To offer only psychological first aid support for emerging personal issues. To refocus on how quality professional practice can be sustained despite personal difficulties. To encourage supervisee to seek specialist help or advice if necessary.	To clearly articulate boundary expectations and requirements in clinical supervision policy. To address any boundary violations or breaches of confidentiality with sensitivity and respect. To deal with issues promptly and appropriately as required (Queensland Health, 2009).
Evaluation and Feedback	To be open to feedback and be prepared to reflect on its value to your professional development. To give appropriate and meaningful feedback to your clinical supervisor. To adhere to any required or agreed feedback and evaluation processes (Proctor, 2011).	To be open and accepting of feedback and to adhere to any required or agreed feedback and evaluation processes.	To monitor and evaluate clinical supervision processes and identify opportunities for improvement (Lynch & Happell, 2008b; The Bouverie Centre, Ryan, Wills, Whittle, & Weir, 2013).
Clinical Supervision Working Agreement (CSWA)	To clarify the supervision process and its limitations with your clinical supervisor and to keep a written copy of your CSWA.	To work within the parameters of your agreed CSWA and to keep a written copy of this agreement.	To foster a workplace culture that supports the clinical supervisor and supervisee(s) to establish and adhere to a mutually agreed CSWA.
Choice	To choose clinical supervision that meets your individual needs. To clearly communicate with a clinical supervisor if you do not wish to continue in a clinical supervisory relationship and withdraw from a clinical supervisory relationship without prejudice.	To take steps to withdraw from a clinical supervisory relationship without prejudice, if required.	To respect supervisee(s) and clinical supervisor(s) right to choice, including choice of clinical supervisor (Australian College of Midwives et al., 2019b). To maintain a record of trained clinical supervisors within the workplace.

Element	Supervisee	Clinical Supervisor	Organisation
Confidentiality	To understand the parameters of confidentiality and to discuss and agree the boundaries of confidentiality at the commencement of clinical supervision and as required thereafter.	To keep the content of clinical supervision confidential except in explicitly agreed circumstances. To clearly disclose to a supervisee if confidentiality needs to be breached (such as breach of legislation, code of conduct, code of ethics or issues of mandatory reporting) (Queensland Health, 2009).	Not to ask clinical supervisors or supervisees to disclose information discussed in clinical supervision sessions.
Session Times	To negotiate an appropriate time with your line manager and provide adequate notice to roster and shift co-ordinators (Queensland Health, 2009). To protect the time for your clinical supervision by giving the sessions a high priority. To be reliable, attend punctually and adhere to negotiated time boundaries. To provide adequate notice if unable to attend a session.	To negotiate an appropriate time with your line manager and provide adequate notice to roster and shift co-ordinators (Queensland Health, 2009). To protect the time for your clinical supervision by giving the sessions a high priority. To be reliable, attend punctually and adhere to negotiated time boundaries. To provide adequate notice if unable to attend a session.	To support clinical supervision with protected time, flexible rostering and budget allocation (White & Winstanley, 2010). To consider impacts on patient safety, service delivery and clinical workload when negotiating clinical supervision session times.
Session Structure	To use the clinical supervision session in the most effective way. To prepare for the session by identifying professional and/or practice issues that you wish to analyse or reflect on, while remaining open to constructive challenge. To make and follow through action plans that arise from your reflection during clinical supervision (Proctor, 2011).	To prepare for the session by ensuring you're in a pre-arranged location without interruptions and settling yourself beforehand.	To support access to rooms and/or technology to enable nurses/midwives to undertake clinical supervision.

Element	Supervisee	Clinical Supervisor	Organisation
Cultural Considerations	To be open to the exploration of issues of cultural diversity within your clinical care and within the clinical supervisory relationship itself. To raise cultural diversity issues if they are not recognised or addressed by the clinical supervisor.	To recognise and sensitively address issues of cultural diversity within the clinical supervision relationship itself and the clinical relationships that are being reflected on (Soheilian, Inman, Klinger, Isenberg, & Kulp, 2014).	To support clinical supervisor education and training that adequately prepares supervisors to recognise, acknowledge and work appropriately with cultural diversity. To support and adhere to organisational cultural policies, guidelines and frameworks in the development and implementation of clinical supervision programs.

10. Formats

Clinical supervision may be conducted in one-to-one sessions, groups (facilitated by a clinical supervisor), or peer groups (where members rotate leadership of the group). The type of supervision will depend on the workplace environment, the availability of clinical supervisors and the preferences of the supervisee(s).

Clinical supervision may be conducted face-to-face, via videoconference, teleconference or e-supervision. Preferred methods will depend on the geographical and workplace considerations, availability of clinical supervisors and the supervisee(s) preferences.

There are benefits and challenges to each of the formats and these need to be considered when deciding which one will best suit individuals, teams and workplaces.

Table 3 provides an overview of location, length and frequency recommendations, which are negotiated and agreed on by the clinical supervisor, supervisee and line manager.

Table 3: clinical supervision location, length and frequency recommendations

Location	• Private location • Away from practice setting (Australian College of Midwives et al., 2019b; Harvey, Spurr, Sidebotham, & Fenwick, 2020; Key, Marshall, & Martin, 2019; White & Winstanley, 2010)	***Location, length and frequency should be negotiated and agreed on by the clinical supervisor, supervisee(s) and line manager.*** ***In line with other professional development activities, professional development leave can be used to support access to clinical supervision.***

Length	• Generally, 1 hour is recommended (White & Winstanley, 2010) but this may vary depending on the:
	  ○ needs of the supervisee(s)
	  ○ work environment (including geographical location and availability of other professional supports)
	  ○ format of clinical supervision (e.g. group sessions usually 1–2 hours in length)
	  ○ availability of clinical supervisors
	• Sessions of less than an hour are not recommended (White & Winstanley, 2010).	

Frequency	• Generally, once a month (White & Winstanley, 2010) • May vary depending on the work environment and needs of the supervisee(s). For example, supervisees who have moved to a new clinical area may require more frequent sessions for a period, or group clinical supervision in dynamic work environments may be offered to staff on a fortnightly basis (Queensland Health, 2009).	

Group clinical supervision

Groups may be deemed to be *open* or *closed.* In *open* groups, membership is a dynamic and ever-changing landscape (Ziller, 1965). Nurses and midwives may join any *open* group clinical supervision that is in session if the nurse or midwife agrees to abide by the rules of engagement of the group.

In *closed* groups, membership remains constant or is relatively stable (Ziller, 1965) and any potential participant must seek approval from the group membership.

Peer group clinical supervision consists of a group of clinical supervisors who rotate the role of group facilitator. This type of group clinical supervision may be useful for clinical supervisors who wish to receive SOS in a group format.

Table 4 provides a summary of benefits and challenges for each format and may assist in identifying which clinical supervision format will be suited to the individual, team or workplace.

Table 4: Summary of benefits and challenges for individual, group and peer clinical supervision formats

	Benefits	Challenges
Individual clinical supervision	Supervisee receives the clinical supervisor's full attention in relation to his/her practice	Supervisee may feel a level of discomfort at the intensity of the one-on-one interaction
	Opportunity for direct focus on areas of individual practice and development	Greater financial cost than group clinical supervision
	A greater focus on the development of the supervisory alliance	No contribution/different perspectives/feedback received from third parties
	A greater sense of safety and security in the dyad	Supervisee unable to compare practice with others
	Supervisee has an increased responsibility to address own practice issues	
Facilitated group clinical supervision	Supervisees can learn from hearing how others address similar practice issues	Clinical supervisors require specific skills in managing groups (which must be balanced with the ability to effectively supervise the group)
	In providing and receiving feedback, supervisees receive a level of self-confirmation and support, and may experience individual growth	Clinical supervisors are more exposed and may experience anxiety or a lack of confidence in their group supervision competence
	More cost effective than individual clinical supervision	Supervisee confidence or group dynamics may make some individuals less likely to actively participate
	Useful if there is a shortage of clinical supervisors or if clinical supervisors have limited time available	Supervisees have less time focused on their individual practice development needs
	Provides opportunity for diversity and challenge in relation to exploring practice issues and potentially uncovering blind spots	Group clinical supervision requires a significant level of trust in order to be effective
	Potential for increased team cohesion	Potential for a poor functioning group to have a negative impact on the supervisees and the supervisory process
	Cost-effective method of providing SOS for clinical supervisors	All supervisees must be trained clinical supervisors and be willing/able to take turns at facilitating the group
Peer group clinical supervision (no designated facilitator)	Supervisees can experience the role of both learner and educator as they provide, and benefit from, the knowledge, experience and wisdom in the peer group	Supervisees must develop clear rules of engagement, and ways of working, which must be reinforced by the group membership to ensure the success of the group function
	Supervisees can negotiate and determine how the group is conducted	Trust is developed over time and the group may need to begin as a closed group until this is established
	Supervisees share responsibility for the success of how the group performs.	Supervisees may be reluctant to challenge each other for fear of offending, creating anxiety, or fracturing a relationship
	Membership can be mutually agreed by members	Unconsciously, the group may appoint a 'de facto' supervisor based on knowledge or skill

Sourced from Moloney, Vivekanda, & Weir, 2007 in The Bouverie Centre et al. (2013, pp. 23-25)

11. Implementation and sustainability of clinical supervision

Queensland is the second largest state in Australia and its 16 HHSs cover rural and remote areas, which provide unique challenges to identifying clinical supervision processes that will work best for their nurses/midwives, teams and organisations. The supervisee, clinical supervisor and organisation each play an integral part in the success of clinical supervision in the workplace. This section will outline some of the key considerations when planning to introduce clinical supervision in the workplace.

Implementation planning

The importance of a well-articulated implementation plan is an essential component to the successful introduction of clinical supervision in the workplace (Colthart et al., 2018; Department of Health and Human Services, 2018; Driscoll et al., 2019; Evans & Marcroft, 2015; Hall, 2018; Hawkins & Shohet, 2012; Kenny & Allenby, 2013; Key et al., 2019; Lynch & Happell, 2008b; Pollock et al., 2017).

Factors associated with successful implementation include:

- the organisational context and culture (Driscoll et al., 2019; Cleary et al., 2010 in Gonge & Buus, 2016; Lynch & Happell, 2008b)
- use of a 'top down' 'bottom up' approach, where leadership support for implementation is balanced with staff consultation and genuine involvement in development of programs (Hawkins & Shohet, 2012; p.243-244, Lynch & Happell, 2008b)
- providing support to new clinical supervisors (Dilworth et al., 2013 in Driscoll et al., 2019)
- support of nurse unit managers (White & Winstanley, 2010).

However, there are several barriers that may impact on the implementation of clinical supervision programs, and these include:

- negative interpretation of the term 'clinical supervision' (Driscoll et al., 2019)
- a poorly coordinated implementation approach (Lynch & Happell, 2008b)
- a lack of trained, available clinical supervisors (White &Winstanley, 2009)
- the amount of time and resources required to plan and implement a clinical supervision program that will meet the unique needs of the individual team or workplace (Driscoll et al., 2019; Lynch & Happell, 2008b).

Effective implementation and sustainability

The key steps for effective implementation and sustainability of clinical supervision programs are outlined below, using an adaptation of the Lynch Model of Implementation and other key examples from the literature (Colthart et al., 2018; Driscoll et al., 2019; Gonge & Buus, 2016; Hawkins & Shohet, 2012; King & Mullan, 2008; Love, 2015; Lynch & Happell, 2008b; White & Winstanley, 2010). Please refer to the Clinical Supervision Implementation Factsheet (Appendix 2.4) for further details on implementation.

Implementation stages:

1. Consider the options and decide whether clinical supervision is the mechanism of support that the organisation wants to pursue at that designated time. Implementing a sustainable clinical supervision program can involve a considerable investment of time and effort.
2. Examine the organisational culture and factors that will support or impede implementation
3. Mobilise organisational support
4. Develop a clinical supervision strategic plan
5. Implement the clinical supervision strategic plan
6. Evaluate the program.

White and Winstanley (2010) recognise that clinical supervision needs to be considered as an essential component of practice, like handover, if it is to be fully integrated into the workplace (White & Winstanley, 2010).

12. Clinical supervision evaluation

Evaluation is an important component of clinical supervision and should be conducted regularly. It assists organisations to monitor the quality and effectiveness of clinical supervision, to rationalise its use and to secure funds and resources to support ongoing clinical supervision programs (Driscoll et al., 2019; Lynch & Happell, 2008a).

Evaluations should be conducted by organisations, the clinical supervisor and supervisee(s), and evaluation methods and frequency should be discussed and agreed at the commencement of each supervisory relationship.

Informal evaluation

This involves regular feedback between the supervisee(s) and the clinical supervisor. It may also include the supervisee', and clinical supervisors', own reflection on their performance.

This feedback may occur verbally or in the form of a written reflection.

Formal evaluation

Formal evaluation should be conducted at regular intervals. There are multiple instruments that may assist with formal evaluations of clinical supervision; these include but are not limited to:

- CSEQ—the Clinical Supervision Evaluation Questionnaire (Horton, Drachler, Fuller, & Leite, 2008) measures supervisees' perspectives on the quality of group clinical supervision. The author's permission is required for use but there is generally no cost associated with its use.
- LASS—the Leeds Alliance in Supervision Scale (Wainwright, 2010) is a very brief three-question scale to assess supervisees' perspectives on the quality of the clinical supervision relationship. It can be used for individual or group clinical supervision. Generally, there is no cost associated with the use of this tool.
- MCSS-26—this research scale was previously known as the Manchester Clinical Supervision Scale and is used to measure the efficacy of clinical supervision from the perspective of the supervisee. This copyrighted scale requires the purchase of an appropriate licence for use (White Winstanley Ltd, 2020).
- WAI—the Working Alliance Inventory is a licenced tool that can be used by the supervisor, supervisee and/or an observer to assess the clinical supervision relationship. Permission must be obtained for use (Horvath, 2020).

The focus of the evaluation may be on the clinical supervisor, the supervisee, the clinical supervisory relationship or other factors, such as:

- outcomes of the person receiving care
- effects on staff morale
- burnout
- sick leave
- recruitment and retention.

13. Conclusion

The clinical supervision journey is one that requires consideration, commitment and planning before commencement. Appropriate preparation, leadership support, wide consultation, governance systems, and choice are essential to the successful implementation of any clinical supervision program in the workplace.

Each HHS/facility/directorate/service will need to forge its own path and implement programs that meet their unique needs. Consideration of geographical location, clinical workloads, leadership and culture are paramount—there is no one recommended pathway to suit every workplace.

The clinical supervision path is long and there are barriers to overcome. Organisations will need to be patient and considered as they plan and implement clinical supervision programs to meet the needs of their workforce.

It is clear that clinical supervision has a positive effect on compassion satisfaction and nurse/midwife wellbeing—it reduces the emotional burden of the work that nurses/midwives do, which, in turn, improves the experience for the people that nurses/midwives care for. Clinical supervision builds confidence, encourages critical thinking, supports safe and ethical practice, and provides opportunities for learning and professional development.

At its core, clinical supervision is about nurses and midwives supporting each other to provide individualised, safe, quality care. In order for this to happen, clinical supervision must be embedded in practice and prioritised by all staff. With transformational leadership, commitment, time and careful planning, organisations can start to build this culture of clinical supervision for nurses and midwives in Queensland.

The clinical supervision journey for nurses and midwives in Queensland is an exciting and hopeful one. It provides an opportunity for restoration, growth and discovery for the nursing and midwifery workforce, with the ultimate goal of improving health and satisfaction outcomes for the people of Queensland.

Appendices

Appendix 1: Glossary

Term	Definition
Clinical supervision	Clinical supervision is a formal professional relationship between two or more people in designated roles, which facilitates reflective practice, explores ethical issues and develops skills (Australian Clinical Supervision Association, 2015).
Clinical supervision coordinator	A nurse or midwife who is a key contact person for clinical supervision within the workplace.
Clinical supervision program	A system of administration, policy, education, training, evaluation, governance and support for clinical supervision in the workplace.
Clinical Supervision Working Agreement (CSWA)	A negotiated agreement that outlines the roles and responsibilities of the clinical supervisor and supervisee(s) within a clinical supervisory relationship. In most cases it will be a signed written agreement but, in some cases (such as open group clinical supervision), it may be verbally contracted by the members. May also be referred to as a contract. The collaborative nature of reaching agreement is also the vehicle for development of the relationship or the alliance (Proctor, 2011).
Clinical supervisor	A skilled professional who assists practitioners in their self-evaluation, critical thinking and overall professional development. A clinical supervisor has completed appropriate education and training in the role and must not be the line manager or friend of a supervisee.
Cultural awareness	Being mindful of the similarities and differences in values, beliefs and orientations of individuals and groups.
Cultural diversity	Cultural diversity encompasses the wide range of differences across the workforce and community. It includes inherent characteristics such as age/generational differences, ethnicity, intellectual and/or physical ability, cultural background, sexual orientation and/or gender identity. Diversity also refers to less visible aspects such as education, socioeconomic background, faith, marital status, job level, family responsibilities, experience, and thinking and work styles (Diversity and inclusion HR Policy G2, 2016).
Cultural safety	Cultural safety requires having knowledge of how one's own culture, values, attitudes, assumptions and beliefs influence their interactions with people and families, the community and colleagues (Code of Conduct for Midwives, 2018).
Debriefing	A process of reviewing circumstance or events in order to provide support and obtain understanding of cause and effects.
Group clinical supervision	A group of individuals with a consistent membership who meet regularly to reflect on their own individual clinical practice in order to develop a greater understanding of practice (Bond & Holland, 2010). Group clinical supervision is facilitated by a designated clinical supervisor.
Individual clinical supervision	A nurse or midwife involved in one-on-one clinical supervision with an approved clinical supervisor.
Line management supervision	Refers to the day-to-day management and organisational supervision required to assist staff with the performance of duties, the adherence to policy and legislative requirements, and the attainment of organisational goals.
Mentorship	A voluntary, long-term, multifaceted developmental relationship where personal, psychological support and career guidance is provided to the mentee by a more experienced person (Queensland Health, 2018a).
Operational supervision	Refers to the day-to-day management and organisational supervision required to assist staff with the performance of duties, the adherence to policy and legislative requirements, and the attainment of organisational goals.

Peer group supervision	A group of peers who meet to reflect on their practice. Peers rotate the role of facilitator among the group, rather than having a designated facilitator (Martin, Milne, & Reiser, 2018). Peer supervision is a separate support mechanism to clinical supervision and should be used as an adjunct (not a replacement) to clinical supervision.
Peer group clinical supervision	A group of peer clinical supervisors who meet for group clinical supervision. The role of facilitator is rotated among the group participants.
Peer supervision	An arrangement where peers work together for mutual benefit (Benshoff, Counselling, & Student Services, 1994). It may be conducted in pairs or groups.
Peer support	Focuses on staff wellbeing and promoting meaningful relationships between peers (Peer Support Program Deployment Guidelines, 2019).
Person receiving care	Used to refer to a person whom the nurse/midwife provides care for. Can be used interchangeably for terms such as a patient, woman, consumer, client, carer, family and/or resident.
Preceptorship	A formal, pre-planned relationship between an experienced and newly registered/ transferred nurse/midwife during which he/she is transitioned to the work environment; supported to develop their competence and confidence as an autonomous professional; refine their skills, values and behaviours; and continue their journey of life-long learning (Queensland Health, 2018a).
Professional supervision	Refers to organisational supervision that monitors standards and performance and assists with the performance of duties and adherence to policy and legislative requirements.
Reflective practice	A process of reviewing and analysing practice in order to develop professionally. Can be undertaken individually (e.g. reflective journal), in a dyad or in a group situation.
Supervisee	A nurse or midwife who is engaged in the process of clinical supervision to reflect on and improve their professional practice, with an appropriately trained clinical supervisor.
Supervision of Supervision (SOS)	The process of a clinical supervisor reflecting on their supervisor role during their own clinical supervision. It assists supervisors to meet their formative, normative and restorative needs. Supervision of Supervision should only be provided by experienced clinical supervisors (Queensland Health, 2009).
Supervisory alliance	Consists of a trusting alliance between the clinical supervisor and the supervisee and is the basis for effective clinical supervision. It is synonymous with 'working alliance' (Australian College of Midwives et al., 2019b; Crockett & Hays, 2015).
Supervisory relationship	A relationship that exists between a clinical supervisor and a supervisee. A strong and trusting supervisory alliance is the cornerstone of an effective clinical supervisory relationship (Australian College of Midwives et al., 2019b; Crockett & Hays, 2015).
Working alliance	Consists of a trusting alliance between the clinical supervisor and the supervisee and is the basis for effective clinical supervision. It is synonymous with 'supervisory alliance' (Australian College of Midwives et al., 2019b; Crockett & Hays, 2015).

Appendix 2: Clinical supervision factsheets

2.1 What to expect in a preliminary clinical supervision session—a fact sheet for supervisees

What is the preliminary clinical supervision session?

The preliminary clinical supervision session provides an opportunity for you to meet with your prospective clinical supervisor to decide whether you would like to work together. The aim of this session is to attempt to establish a relationship and rapport, and discuss the ways in which you would like to work together and explore goals and expectations. This session will assist you in determining if you would like to work together on an ongoing basis.

What should I expect?

This is an opportunity for you, as the supervisee, to determine whether you feel a sense of comfort or 'fit' with your potential clinical supervisor. This may not always happen and should not be seen as a loss or a failure.

Research indicates that the strength of the initial contact may be indicative of the development of an effective clinical supervision relationship; therefore, it's important that both parties feel comfortable during this initial meeting.

While this initial meeting should feel like a conversation between you and your supervisor, there are several issues that your clinical supervisor will raise for discussion. The purpose of this is to negotiate the ways in which you and your clinical supervisor will work together, to ensure you have a shared understanding of expectations of each other and the clinical supervision process.

Topics that are likely to be discussed in this first session include:

- booking session dates, rooms and times
- best methods of communication
- how to schedule or cancel a session
- confidentiality—what is confidential and what is not. What process will be undertaken if a legal, ethical or mandatory reporting issue needs to be escalated?
- documentation—what records will be kept, where will they be stored and for how long?
- establishing goals and preparing topics for future clinical supervision sessions. This involves exploration of what content may be helpful for you to bring for discussion in clinical supervision.
- how you will evaluate the clinical supervision sessions and how frequently this will occur.

How should I prepare for this preliminary clinical supervision session?

All potential supervisees should receive an orientation or introduction to clinical supervision in their workplace, prior to selecting a clinical supervisor. This may be a face-to-face session, or in the form of an online education session or video.

Before you attend the preliminary clinical supervision with your chosen supervisor, you should prepare any questions that you would like to ask. They may be related to concerns or queries you have regarding any aspect of clinical supervision; whether it be regarding confidentiality, record keeping or finding time for clinical supervision in your busy work schedule, this is a great opportunity to raise those issues.

As this session is dedicated to establishing the ways that you and your clinical supervisor will work together, you do not necessarily need to prepare a clinical case for reflection.

Deciding whether to establish a Clinical Supervision Working Agreement

At the end of this preliminary clinical supervision session, you and the clinical supervisor should have an idea of whether you would like to continue to work together. Sometimes this is very clear to both parties and other times it will be less clear.

The working alliance between the clinical supervisor and supervisee is one of the most important factors in effective clinical supervision and, therefore, both parties should feel comfortable when entering the relationship. It's for these reasons that it's also important that both parties feel comfortable to withdraw from the relationship without prejudice.

It does take time to establish a working alliance and sometimes you may need to meet with your clinical supervisor several times before you are comfortable that you would like to work with that person. The literature suggests that it can take up to five one-hour sessions to achieve this level of comfort.

The topics that you have discussed during the preliminary clinical supervision session will form the basis of the Clinical Supervision Working Agreement (CSWA). As noted above, it may take a few sessions to decide whether you would like to work together but once this has been established your CSWA should be finalised.

What happens next?

If you decide not to proceed past the preliminary session with a particular clinical supervisor, please be clear and let them know that. If both you and the clinical supervisor agree that you would like to work together, then the work that you have done to this point will assist you in completing the CSWA. This document should contain the key points that you have agreed with your clinical supervisor, including how often (and for how long) you have agreed to meet, your goals and expectations and how you intend to evaluate the sessions. Both the clinical supervisor and supervisee should keep a copy of this document, and you may also be required to provide a copy to your line manager or other contact person in the workplace.

References

Australian College of Midwives, Australian College of Nursing, & the Australian College of Nurses Inc. (2019a). *Clinical Supervision for Nurses: Background Paper.* Retrieved from www.acmhn.org/career-resources/clinical-supervision.

Key, S., Marshall, H., & Hollins Martin, C. J. H. (2019). The Scottish clinical supervision Model for Midwives. *British Journal of Midwifery. 27* (10). 655-663. doi:10.12968/bjom.2019.27.10.655.

Martin, P., Lizarondo, L., & Kumar, S. (2018). A systematic review of the factors that influence the quality and effectiveness of telesupervision for health professionals. *Journal of Telemedicine and Telecare*, 24(4), 271-281. doi:10.1177/1357633x17698868.

Queensland Health. (2009). *Clinical supervision guidelines for mental health services*, October 2009. Brisbane: Queensland Health. Retrieved from https://www.health.qld.gov.au/qcmhl/supervision_res.

2.2 Clinical supervision—FAQs

What is clinical supervision?

Clinical supervision is a process whereby nurses/midwives can meet voluntarily to discuss and reflect on their clinical practice. This occurs either one-on-one or in a group setting. Nurses and midwives may meet face to face in dyads, in small groups of 6–8, or via e-supervision (telephone, video or email).

The work of nurses and midwives in contemporary healthcare settings is both demanding and burdensome. Clinical supervision provides a forum for nurses/midwives to receive support and restoration and to maintain safety of practice by reinforcing the ethics and legalities of practice. It further provides an opportunity for learning, which ultimately strengthens and develops practice.

Is clinical supervision confidential?

The fact that a nurse or midwife engages in clinical supervision is **not confidential.** Workplaces will usually keep a record of staff involved in clinical supervision activities that are conducted during work time.

However, the content of the nurse/midwife's clinical supervision **is confidential** unless it breaches ethical or legal boundaries of nursing and midwifery practice. The parameters of confidentiality should be clearly articulated in the written CSWA for both individual and group clinical supervision.

What is the difference between clinical supervision and therapy?

Clinical supervision is not therapy. Therapy focuses on personal issues, with an aim of achieving personal growth. Clinical supervision focuses on professional practice issues, with the objective of professional development. The focus of clinical supervision is to assist nurses and midwives to manage and resolve clinical practice issues and challenges in order to develop their practice as a nurse or midwife. Individual development often occurs but this is through focusing a lens on professional practice not on personal issues.

Don't I already receive clinical supervision from my line manager?

Line management supervision is different to clinical supervision. In line management supervision the line manager seeks to support the nurse/midwife to meet professional standards and to assist them to identify clinical, professional and career development goals that align with the organisation's needs.

In clinical supervision, clinical supervisors seek to understand what the individual nurse/midwife hopes to achieve and then supports them in achieving their goals. Therefore, the relationship an individual nurse/midwife will have with their clinical supervisor versus their line manager differs in terms of purpose, agenda, autonomy and goal setting.

How do I find the time for clinical supervision?

The world of healthcare is often busy and chaotic. As with all professional development activities, clinical supervision can be scheduled and facilitated to suit individual practice environments. While this can certainly be a challenge in some workplace environments, nurses/midwives have found creative ways to support each other to access this valuable support. The evidence would also suggest that the busier nurses and midwives become, the greater their need for clinical supervision.

What do I get out of clinical supervision?

Clinical supervision, delivered effectively, consists of three component parts:

Restorative

Clinical supervision has a support and healing component that provides restoration. It provides nurses/midwives with a safe and supportive space to think about and reflect on the work they do. This can empower nurses/midwives to deal with workplace issues better and supports their wellbeing.

Normative

The normative function of clinical supervision supports safe and ethical practice by focusing on competence, accountability and adherence to clinical, organisational and professional standards.

Formative

Clinical supervision provides the opportunity for learning, development and the strengthening of practice as part of professional development. It has been shown to improve practice by supporting nurses/midwives to find their own solutions and answers to practice issues.

How does clinical supervision work?

Clinical supervision should occur regularly in a private space, and in a protected time, away from the clinical practice area. Nurses and midwives are supported to choose their clinical supervisor and to decide which professional issues they would like to discuss. It should be noted that line managers **should not** provide clinical supervision to their own staff.

What should I expect in clinical supervision?

During your initial session, expectations should be clearly articulated to all participants in relation to structure, boundaries, objectives and goals. Relationships developed in clinical supervision should be respectful, supportive and culturally safe.

How will I prepare to engage in clinical supervision?

Nurses and midwives should receive an introduction to the clinical supervision process and how to become a supervisee. Clinical supervisors must receive adequate preparation, training and ongoing support to undertake their role.

How can I become a clinical supervisor?

All clinical supervisors must undertake appropriate and specific education and training in clinical supervision prior to commencing in the role. Clinical supervisors should meet the following eligibility criteria for training:

- five or more years of experience in clinical practice
- demonstrated clinical supervisor skills and attributes, such as warmth, openness and curiosity
- current participation in own clinical supervision, preferably for 12 months or more
- line manager and clinical supervisor endorsement to train as a clinical supervisor.

How can I find out more about clinical supervision?

If you have not received any information about clinical supervision in your workplace, check with your line manager—they may be able to assist. Some workplaces will have contact people, procedures or guidelines in place to assist. If your workplace does not have an established clinical supervision program yet, you can still access clinical supervision from external providers.

References

Australian College of Midwives, Australian College of Nursing, & The Australian College of Nurses inc. (2019a). *Clinical Supervision for Nurses: Background Paper.* Retrieved from http://www.acmhn.org/career-resources/clinical-supervision.

Australian College of Midwives, Australian College of Nursing, & The Australian College of Nurses inc. (2019b). *Position Statement on Clinical Supervision for Nurses and Midwives.* Retrieved from http://www.acmhn.org/images/stories/2019_Joint_PS_ClinicalSupervision3.pdf.

Driscoll, J., Stacey, G., Harrison Dening, K., Boyd, C., & Shaw, T. (2019). Enhancing the quality of clinical supervision in nursing practice. *Nursing Standard, 34(*5), 43-50.doi: 10.7748/ ns. 2019.e11228.

Hall, I. (2018). Implementing a sustainable clinical supervision model for Isles nurses in Orkney. *British Journal of Community Nursing, 23*(3),136-139. doi:10.12968/bjcn.2018.23.3.136.

Harvey, S., Spurr, P., Sidebotham, M., & Fenwick, J. (2020). Describing and evaluating a foundational education/training program preparing nurses, midwives and other helping professionals as supervisors of clinical supervision using the Role Development Model. *Nurse Education in Practice. 42.* 1-7. doi.org/10/1016/j.nepr.2019.10267.

Hawkins, H., & Shohet, R. (2012). *Supervision in the Helping Professions.* Maidenhead: Oxford University Press.

Love B., Sidebothamb, M., Fenwick, J., Harvey, S., & Fairbrothere, G. (2017). Unscrambling what's in your head: A mixed method evaluation of clinical supervision for midwives. *Women and Birth. 30(*4),271-281. http://dx.doi.org/10.1016/j.wombi.2016.11.002.

Queensland Health. (2009). *Clinical supervision guidelines for mental health services*, October 2009. Brisbane: Queensland Health. Retrieved from https://www.health.qld.gov.au/qcmhl/supervision_res.

White, E., & Winstanley, J. (2009). Implementation of clinical supervision: educational preparation and subsequent diary accounts of the practicalities involved, from an Australian mental health nursing innovation, *Journal of Psychiatric and Mental Health Nursing,16.* 895-903.

2.3 Line manager—FAQs

My staff have asked for clinical supervision. What is it?

Clinical supervision is a process whereby nurse/midwives meet voluntarily with a clinical supervisor to discuss and reflect on their clinical practice, with the goals of: providing support; maintaining safety; developing practice; and improving the care experience for the people that nurses/midwives care for.

Should all nurses and midwives attend clinical supervision?

While clinical supervision is recommended for all nurses and midwives, it is a voluntary professional development activity and some nurses/midwives may choose not to participate.

How do I find a clinical supervisor for my staff?

Does your workplace/service/HHS have a clinical supervision program in place? If so, there should be a contact person who holds a list of available clinical supervisors. If there are no available clinical supervisors in your area, then you may want to discuss the possibility of implementing clinical supervision with your nursing director. This process takes time and commitment but is more sustainable in the long term. In the meantime, you may be able to develop a partnership with a service/workplace/HHS that has an established program or access an external clinical supervisor (the Australian Clinical Supervision Association maintains lists of clinical supervisors on their website).

My staff member wants an external clinical supervisor—do I need to pay for this?

No. Staff may choose to access an external clinical supervisor and this would generally be funded in the same manner as other professional development entitlements.

We are a remote service—how can we access clinical supervision?

Clinical supervision can be conducted via telephone, video or email. You may find that some clinical supervisors will have capacity to travel to regional or remote areas, at the cost of your service.

How do staff choose between group and individual clinical supervision?

This is a personal choice. There are different benefits and challenges to both (as described in the Clinical Supervision Framework). Initially, decisions around this may be based on clinical supervisor availability and staff preferences. Ideally, all staff should be offered individual clinical supervision, with group clinical supervision being a powerful adjunct.

Does clinical supervision have to be conducted in work time?

Clinical supervision is a professional development activity and, therefore, should be conducted in work time. In line with other professional development activities, professional development leave may be used to access clinical supervision.

One of my staff has trained as a clinical supervisor. Can they supervise their colleagues?

No. A clinical supervisor cannot supervise someone in their clinical area, or someone that they have a dual relationship with (e.g. someone they line manage, or a friend).

My staff member has found a clinical supervisor who is an hour's drive from our service, so their round trip for clinical supervision is three hours. Should I approve this?

It is important that the supervisee is able to choose their clinical supervisor, and some people may be prepared to travel a considerable distance for this. Depending on your work environment, and availability of local clinical supervisors, it may not be reasonable to approve extended travel time within working hours. You should check whether your workplace has a policy or procedure addressing this.

My staff member has found a clinical supervisor but I don't know if they have completed a training course. Is this okay?

To access clinical supervision in work time, the clinical supervisor should meet the criteria outlined in the Clinical Supervision Framework. It is reasonable to ask a nurse/midwife to provide the required details for their chosen clinical supervisor, prior to approving leave to attend. If the person does not meet the criteria for a clinical supervisor, they may still offer support to the clinician (e.g. debriefing, mentoring, peer support) but it is not clinical supervision.

We had a busy shift and were unable to replace sick leave. A staff member had clinical supervision pre-arranged and left the ward anyway. Is this okay?

Session times need to be negotiated with line managers in advance. If there's an unforeseen increase in clinical workload, then all steps should be taken to support the nurse/midwife's attendance at clinical supervision. If this is not possible, then the clinical supervision session may need to be rescheduled.

My staff member has been receiving clinical supervision for some time and their practice issues are not improving. Can I ask their clinical supervisor for updates on their progress?

No. The content of clinical supervision is confidential (unless it breaches ethical or legal boundaries of professional practice) and, therefore, clinical supervisors cannot discuss issues raised in the sessions and should not be asked to do so.

An issue has occurred with a staff member. Should I notify their clinical supervisor of this so they can help the staff member during their clinical supervision sessions?

No. Clinical supervision sessions are clinician-led and supervisees will choose which clinical issues they want to discuss during each session. Clinical supervisors should not be approached with information about their supervisees.

If I can't ask a clinical supervisor for updates or feedback, how do I know that the sessions are worthwhile?

There are a number of ways that clinical supervision can be evaluated, and it is recommended that organisations collect this data. Please see the Clinical Supervision Framework for more information on evaluation methods.

2.4 Clinical supervision implementation factsheet

The importance of a well-articulated implementation plan has been widely recognised in the international literature (Driscoll et al., 2019; Evans & Marcroft, 2015; Hall, 2018; Hawkins & Shohet, 2012; Kenny & Allenby, 2013; Key et al., 2019; Lynch & Happell, 2008a; Pollock et al., 2017).
The key features of successful implementation of clinical supervision programs have been summarised below, using an adaptation of the Lynch Model of Implementation and other key examples from the literature (Colthart et al., 2018; Driscoll et al., 2019; Gonge & Buus, 2016; Hawkins & Shohet, 2012; King & Mullan, 2008; Love et al., 2017; Lynch & Happell, 2008a; Lynch & Happell, 2008b; White & Winstanley, 2010).

1. Consider the options

Is clinical supervision the mechanism of support that the organisation wants to pursue? The organisation needs to have a clear understanding of what clinical supervision is and whether this, or another support strategy, is what is required to meet organisational goals.

2. Assess organisational culture

Knowledge of the culture of the organisation is vital and developing a level of interest and curiosity within the organisation in relation to clinical supervision is essential.

The context in which clinical supervision is implemented has been identified as more important than the clinical supervision itself and organisations with strong cultures of learning and innovative leadership have greater success.

Clinical supervision as a concept must also be perceived by the organisation as valued and essential to the practice of nursing. It must be incorporated into nursing practice in the same manner that clinical handover is valued and incorporated into the practice of nursing.

Identify forces of influence

The organisation examines and prioritises forces that will support or provide resistance to the implementation of clinical supervision. There is also a need to identify differences in the level of power or influence in 'pushing and resisting' forces for the implementation of clinical supervision.

Strategies that have been demonstrated to support successful implementation (also known as 'pushing forces') include:

- staged implementation
- guidelines agreed
- clinical supervision champions
- designated clinical supervision coordinator
- providing information to potential supervisees (that focuses on the supportive nature of clinical supervision)

Factors that have negative impacts on the implementation of clinical supervision implementation (also known as 'resisting forces') are:

- lack of support from the organisation
- lack of support from line managers
- a negative interpretation of the term 'clinical supervision'
- a culture of mistrust.

3. Mobilising organisational support

Involves the identification of resources required to progress the clinical supervision program further. Resources could include time and space, budget, personnel and the identification of clinical supervision champions. Once

these details are established, a decision can be made on whether resources are available to progress with implementation.

4. Developing the clinical supervision strategic plan

Successful implementation of a clinical supervision program requires consideration of the individual culture of the organisation and the supervisees' needs, as opposed to the use of an 'expert' clinical supervision model.

A negative interpretation of the term 'clinical supervision' has also been identified as a challenge; therefore, communicating a clear definition of clinical supervision is vital if it is not to be confused with other forms of supervision or professional support such as line management supervision or preceptorship/mentorship/clinical education or facilitation.

Clearly articulating the aims and objectives of clinical supervision, as opposed to other organisational strategies, is integral. Developing a clinical supervision marketing strategy, which provides a consistent and single-minded message about what clinical supervision is (and is not), can assist to achieve this in the implementation phase.

Strategic development includes consultation with key stakeholders and wide consultation across all levels of nursing. The concept of having a 'top down, bottom up' approach has been highlighted as a crucial success factor. This concept recognises that leadership support for implementation, and sustainability of clinical supervision programs and the identification of leadership champions, is imperative to the success of the program. This should be balanced with staff consultation ('bottom up' approach) and genuine involvement in the development of clinical supervision programs (note that the support of nurse unit managers is a key requirement for successful implementation).

A high degree of consultation is required and the use of focus groups, interviews and meetings with key personnel is suggested. The findings from the consultation process should inform the development of the clinical supervision program. The strategic plan should also address the management of factors identified as 'pushing' or 'resisting' forces.

5. Implementing the clinical supervision strategic plan

During this stage, a clinical supervision committee/working party should be established and a clinical supervision coordinator appointed. Policies/guidelines, systems of governance, clinical supervisor training, supervisee awareness sessions, and marketing and communication strategies are developed and implemented. Providing support to new clinical supervisors is also integral to the successful implementation of clinical supervision programs.

This stage should also include the introduction of clinical supervision activity in a small, distinct clinical setting initially, with expansion to other areas as part of a staged implementation plan.

Addressing the culture of the organisation several times during implementation is imperative in order to respond to changing climate and evolving need.

6. Evaluation

Evaluation of the success of the clinical supervision project is required. This involves assessing outcomes, the sustainability of the program and identifying whether any of the steps undertaken on the clinical supervision journey need to be repeated. There is a need to gather evidence that captures the impact and outcomes the clinical supervision program may be influencing or achieving. This is particularly important in 'winning the resource argument' (Butterworth & Faugier 1992; p. 232 in Lynch & Happell, 2008b, p.71).

Conclusion

Implementation of clinical supervision programs have been noted to be lengthy and demanding. A poorly coordinated approach to clinical supervision implementation is problematic as it can reaffirm some of the myths of clinical supervision and reduce or negate the potential benefits.

In navigating this journey it is, therefore, vital to consult widely and to establish a program that is the best fit for the individuals, teams and culture of the organisation.

References

Bond, M., & Holland, S. (2010*). Skills of clinical supervision for Nurses. A Practice Guide for supervisees, clinical supervisors and Managers*. Maidenhead: Oxford University Press.

Colthart, I., Duffy, K., & Blair, V. (2018). Keeping support and clinical supervision on your agenda. *Nurs Manag (Harrow), 25*(5), 20-27. doi:10.7748/nm.2018.e1804.

Driscoll, J., Stacey, G., Harrison Dening, K., Boyd, C., & Shaw, T. (2019). Enhancing the quality of clinical supervision in nursing practice. *Nursing Standard, 34*(5), 43-50.

Evans, C., & Marcroft, E. (2015). clinical supervision in a community setting. *Nursing Times, 111*(22), 16-18.

Gonge, H., & Buus, N. (2016). Exploring Organizational Barriers to Strengthening clinical supervision of Psychiatric Nursing Staff: A Longitudinal Controlled Intervention Study. *Issues in Mental Health Nursing, 37*(5), 332-343. doi:10.3109/01612840.2016.1154119.

Hawkins, P., & Shohet, R. (2012). *Supervision in the Helping Professions.* Maidenhead: Oxford University Press.

Kenny, A., & Allenby, A. (2013). Implementing clinical supervision for Australian rural nurses. *Nurse Education in Practice, 13*(3), 165-169. doi:http://dx.doi.org/10.1016/j.nepr.2012.08.009.

Key, S., Marshall, H., & Martin, C. J. H. (2019). The Scottish clinical supervision Model for midwives. *British Journal of Midwifery, 27*(10), 655-663. doi:10.12968/bjom.2019.27.10.655.

King, R., & Mullan, G. (2008). clinical supervision In C. Lloyd, King, R, Deane, F & Gournay, K. (Ed.), *Clinical Management in Mental Health Services.* Chichester West Sussex.: Wiley-Blackwell.

Love, B., Sidebotham, M., Fenwick, J., Harvey, S., & Fairbrother, G. (2017). "Unscrambling what's in your head?"A mixed method evaluation of clinical supervision for midwives. *Women and Birth, 30,* 271-281.

Lynch, L., & Happell, B. (2008a). Implementation of clinical supervision in action: Part 3: The development of a model. *International Journal of Mental Health Nursing, 17,* 73-82. doi:10.1111/j.1447-0349.2007.00513.x.

Lynch, L., & Happell, B. (2008b).Implementation of clinical supervision in action: Part 2: Implementation and beyond. *International Journal of Mental Health Nursing, 17,* 65-72.

Pollock, A., Campbell, P., Deery, R., Fleming, M., Rankin, J., Sloan, G., & Cheyne, H. (2017). A systematic review of evidence relating to clinical supervision for nurses, midwives and allied health professionals. *Journal of Advanced Nursing (John Wiley & Sons, Inc.), 73*(8), 1825-1837. doi:10.1111/jan.13253.

White, E., & Winstanley, J. (2010). A randomized controlled trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing, 15*(2), 151-167.

Appendix 3: Clinical supervision resources

3.1 Sample individual Clinical Supervision Working Agreement/Contract

Clinical Supervision Working Agreement

Clinical supervisee	
Clinical supervisor	
Goals and expectations	
Clinical supervisee goals	
Clinical supervisor expectations	
Structure of supervision sessions	
Frequency **Duration** **Location**	
Evaluation of clinical supervision sessions	
Evaluation method	
Evaluation frequency (recommended 3 months initially and then 12 monthly thereafter)	
Limits to confidentiality	To be clearly outlined and agreed to by clinical supervisor and clinical supervisee
Supervision records	Record-keeping arrangements to be discussed and agreed on, including appropriate storage of any clinical records
Content of supervision	To be negotiated in confidence between supervisee and clinical supervisor. This should include a list of the knowledge and skills that the supervisee would like to develop in supervision sessions and should be regularly reviewed and renegotiated between the clinical supervisor and supervisee.

Supervisee name:	**Clinical supervisor name:**
Signature:	**Signature:**
Date:	**Date:**

3.2 Sample group Clinical Supervision Working Agreement/Contract

Group Clinical Supervision Working Agreement

Clinical supervisor(s)	
Group supervision frequency/duration/location	
Goals and expectations	
Clinical supervisee(s) goals	
Clinical supervisor(s) and supervisees expectations	
Evaluation of clinical supervision sessions	
Evaluation method and frequency	
Limits to confidentiality	To be clearly outlined and agreed to by clinical supervisor and clinical supervisee
Supervision records	Record keeping arrangements to be discussed and agreed on, including appropriate storage of any clinical records
Content of supervision	To be negotiated in confidence between supervisees and clinical supervisor(s) and should be regularly reviewed and renegotiated between the supervisor(s) and supervisee(s)

Supervisor name:	**Supervisor name:**
Signature:	**Signature:**
Date:	**Date:**

Supervisee name:	**Supervisee name:**
Signature:	**Signature:**
Date:	**Date:**

Supervisee name:	**Supervisee name:**
Signature:	**Signature:**
Date:	**Date:**

Supervisee name:	**Supervisee name:**
Signature:	**Signature:**
Date:	**Date:**

Supervisee name:	**Supervisee name:**
Signature:	**Signature:**
Date:	**Date:**

Supervisee name:	**Supervisee name:**
Signature:	**Signature:**
Date:	**Date:**

3.3 Attendance sheet sample

Clinical Supervision Attendance Sheet

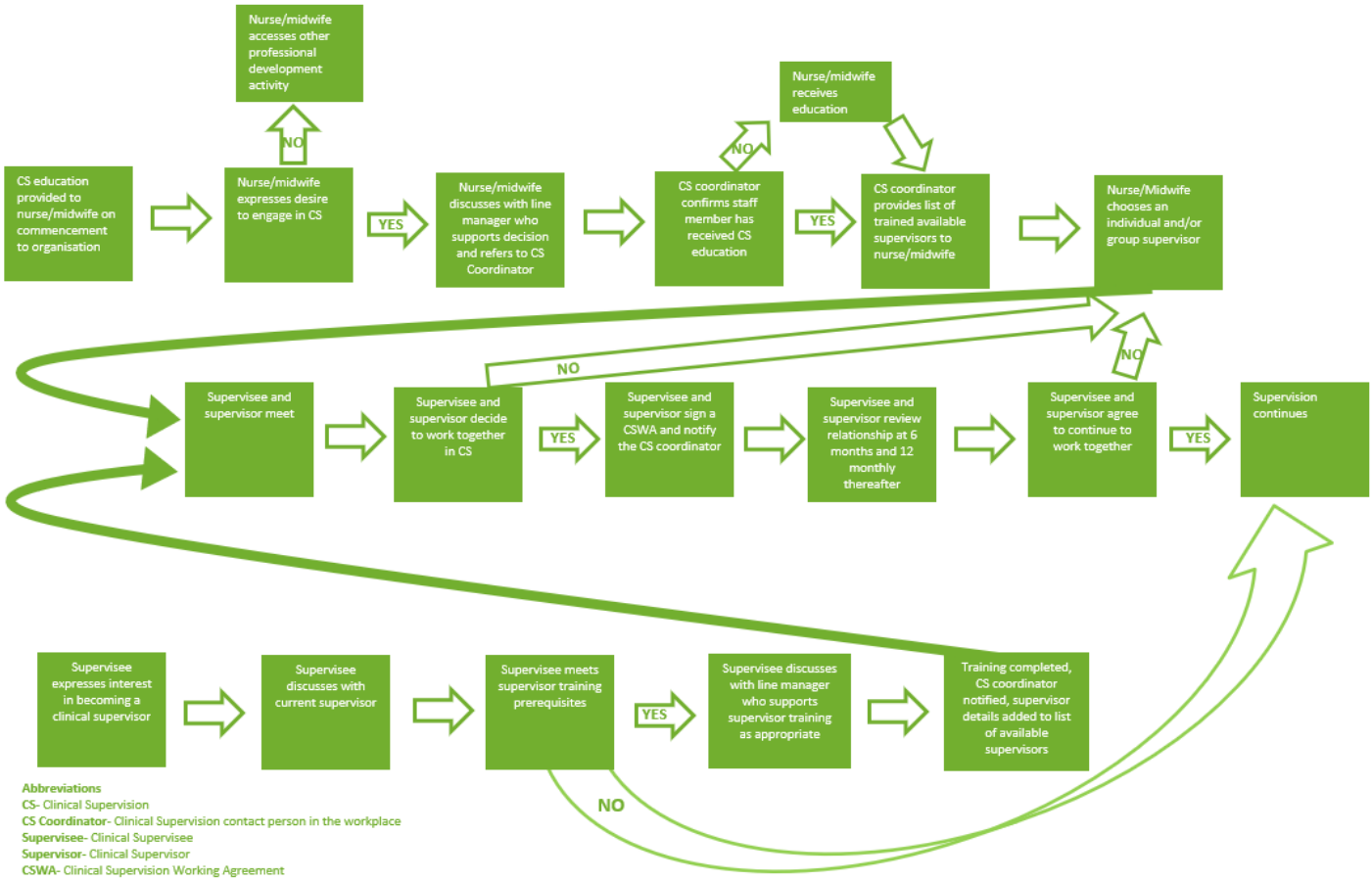
Clinical supervisor name:

Clinical supervisee name:

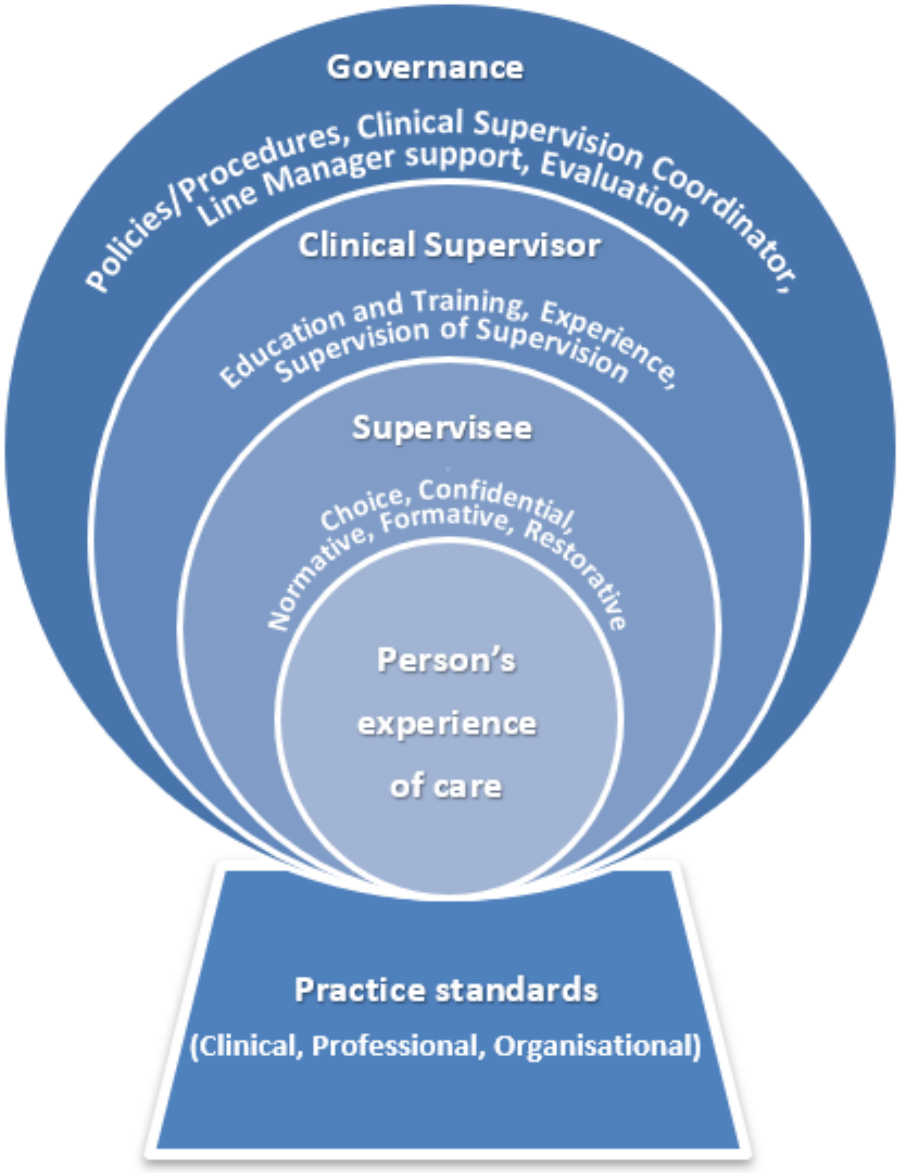
Date	Time	Type of contact	Comments	Supervisor/supervisee signatures (if required)

Type of contact	Code	Type of contact	Code	Type of contact	Code
Individual	I	Face to face	F	Video	V
Group	G	Phone	P	Email	E

3.4 Clinical supervision process flowchart



3.5 Diagrammatical representation of clinical supervision framework



3.6 Sample procedure

Purpose and intent

This hospital health service (HHS) promotes a culture of lifelong learning that aligns with Section 12.3 of the *Framework for Lifelong Learning for Nurses and Midwives Queensland Health—June 2018: Supporting Relationships to Build Capacity: Clinical Supervision* (Queensland Health, 2018, p. 54). The value of clinical supervision for all nurse/midwives is recognised for its contribution to quality care and staff wellbeing.

Clinical supervision is defined as:

> '*A formally structured professional arrangement between a supervisor and one or more supervisee(s). It is a purposely constructed regular meeting that provides for critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice. Clinical supervision facilitates development of reflective practice and the professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace*'.

(Australian College of Midwives, Australian College of Nursing, & The Australian College of Mental Health Nurses inc., 2019, p.2)

Scope and target audience

The term clinical supervision has several other meanings and applications in healthcare. For the purposes of this document, clinical supervision does not refer to the direct or indirect supervision of a student or a colleague's work practice (including observational assessment), nor does it refer to managerial supervision or mentorship (Australian College of Midwives et al., 2019; Martin et al., 2017; HETI, 2013).

This procedure applies to all nurses/midwives employed within the HHS.

Principles

As outlined in the *Clinical Supervision Framework for Queensland Nurses and Midwives* (2021), clinical supervision:

- should be available to all nurses and midwives regardless of their level or role
- requires a trusting alliance between the clinical supervisor and supervisee(s)
- provides a safe and confidential space for nurses and midwives to critically reflect on their practice
- is a supportive, culturally safe process that contributes to the health and wellbeing of nurses and midwives.

Adapted from (Australian College of Midwives et al., 2019)

Procedure/process

To access clinical supervision, nurse/midwives follow these steps:

1. Attend/view a clinical supervision awareness session on commencement of employment. At this time, nurses/midwives will receive details of the local clinical supervision coordinator, available clinical supervisors and/or available clinical supervision group times.
2. Select a clinical supervisor and/or group clinical supervision of their choice from the list of approved options.
3. Discuss proposed clinical supervision arrangements with their line manager and negotiate attendance details.
4. Meet with their potential individual clinical supervisor for a preliminary clinical supervision session. Following this session, both the clinical supervisor and supervisee decide whether to continue in a formalised clinical supervisory relationship.

5. When a formalised clinical supervision relationship commences:
    a. the *clinical supervision working agreement* (CSWA) is negotiated and signed
    b. the supervisee must negotiate their attendance needs with their line manager. This will assist line managers to maintain adequate rostering for the clinical area.
    c. the clinical supervisor notifies the local clinical supervision coordinator of the arrangement.

Clinical supervisor responsibilities

Clinical supervisors must:

- complete appropriate clinical supervision education and training for nurses/midwives
- maintain their own clinical supervision
- supply a copy of each CSWA to the local clinical supervision coordinator
- notify the clinical supervision coordinator when:
- a new CSWA commences
- a CSWA ceases
- there is a change in their own clinical supervision arrangements
- attend a clinical supervision refresher (or alternative professional development activity) every three years
- complete and submit a re-certification form to the clinical supervision coordinator every three years.

Line manager responsibilities

Supervisees must consult with their line manager regarding their clinical supervision arrangements. Line managers offer support to clinical supervision by supporting staff:

- access to protected time to provide/receive clinical supervision
- attendance at clinical supervision education and training as appropriate.

Clinical supervision coordinator

The role of this nominated individual (or group of individuals) is to:

- coordinate access to a clinical supervision awareness session/video for nurse/midwives on commencement of employment
- maintain a register of available clinical supervisors
- maintain a register of nurse/midwifery staff receiving clinical supervision
- act as a champion and key contact person for clinical supervision.

Cessation of Clinical Supervision Working Agreement

A CSWA ceases when either of the following occurs:

- either party notifies of their intention to withdraw from the clinical supervisory relationship
- contact between clinical supervisor and supervisee has ceased and attempts to contact each other have failed.

Definition of terms

Term	Definition
Clinical supervision	Clinical supervision is a formal professional relationship between two or more people in designated roles, which facilitates reflective practice, explores ethical issues, and develops skills (Australian Clinical Supervision Association, 2015).
Clinical supervisor	A skilled professional who assists practitioners in their self-evaluation, critical thinking and overall professional development. A clinical supervisor has completed appropriate education and training in the role and must not be the line manager or friend of a supervisee.
Clinical supervision coordinator	A nurse or midwife who is a key contact person for clinical supervision in the workplace.
Clinical Supervision Working Agreement	A negotiated agreement that outlines the roles and responsibilities of the clinical supervisor and supervisee(s) in a clinical supervisory relationship. In most cases, it will be a signed written agreement but, in some cases (such as open group clinical supervision), it may be verbally contracted by the members. May also be referred to as a contract. The collaborative nature of reaching agreement is also the vehicle for development of the relationship or the alliance (Proctor, 2011).
Group clinical supervision	A group of individuals with a consistent membership who meet regularly to reflect on their own individual clinical practice in order to develop a greater understanding of practice (Bond & Holland, 2010). Group clinical supervision is facilitated by a designated clinical supervisor.
Supervisee	A nurse or midwife who is engaged in the process of clinical supervision to reflect on and improve their professional practice, with an appropriately trained clinical supervisor.

References

Australian Clinical Supervision Association. (2015). *Clinical supervision*. Retrieved from http://clinicalsupervision.org.au/clinical-supervision/.

Australian College of Midwives, Australian College of Nursing, & The Australian College of Mental Health Nurses inc. (2019b). *Position Statement: Clinical Supervision for Nurses and Midwives*. Retrieved from https://www.midwives.org.au/resources/clinical-supervision-nurses-and-midwives-joint-position-statement-2019.

Bond, M., & Holland, S. (2010). *Skills of Clinical Supervision for Nurses. A Practice Guide for* Supervisees, Clinical Supervisors and Managers. . Maidenhead: Oxford University Press.

Cummins, A. (2009). Clinical supervision: The way forward? A review of the literature. *Nurse Education in Practice, 9,* 215-220.

Health Education and Training Institute. (2013). T*he Superguide: A Supervision Continuum for Nurses and Midwives.* HETI. Sydney.

Martin, P., Kumar, S., & Lizarondo, L. (2017). When I say … clinical supervision. *Medical Education, 51*(9), 890-891. doi:10.1111/medu.13258.

Proctor, B. (2011). Training for the supervision alliance. In J. Cutcliffe, R,, K. Hyrkas, & J. Fowler (Eds.), *Routledge Handbook of Clinical Supervision, Fundamental International Themes.* New York: Routledge.

Queensland Health. (2018a). *Framework for lifelong learning for nurses and midwives* (Queensland Health), June 2018. Brisbane,QLD: State of Queensland (Queensland Health)

References

Ashburner, C., Meyer, J., Cotter, A., Young, G., & Ansell, R.(2004). Seeing things differently: Evaluating psychodynamically informed group clinical supervision for general hopsital nurses. *Journal of Research in Nursing, 9*(1), 38-48.

Australian Clinical Supervision Association. (2015). *Clinical supervision.* Retrieved from http://clinicalsupervision.org.au/clinical-supervision/.

Australian College of Midwives, Australian College of Nursing, & The Australian College of Mental Health Nurses inc. (2019a). *Clinical Supervision for Nurses and Midwives: Background Paper.* Retrieved from http://www.acmhn.org/career-resources/clinical-supervision. Viewed 20th February 2020.

Australian College of Midwives, Australian College of Nursing, & The Australian College of Mental Health Nurses inc. (2019b). *Position Statement: Clinical Supervision for Nurses and Midwives.*Retrieved from http://www.acmhn.org/images/stories/2019_Joint_PS_ClinicalSupervision3.pdf. Viewed 20th February 2020.

Bambling, M., King, R., Schweitzer, R., & Raue P. (2006). Clinical supervision: its influence on client-rated working alliance and client symptom reduction in brief treatment of depression. *Psychotherapy Research, 16,* 317-331.

Barnett, J. E., & Molzon, C. H. (2014). Clinical Supervision of Psychotherapy: Essential Ethics Issues for Supervisors and Supervisees. *Journal of Clinical Psychology, 70*(11), 1051-1061. doi:DOI:10.1002/jclp.22126.

Beddoe, L. (2017). Harmful supervision: A commentary. *The Clinical Supervisor, 36*(1), 88-101. doi:doi.org/10.1080/07325223.2017.1295894.

Bégat, I., Ellefsen, B., & Severinsson, E. (2005). Nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of well-being -- a Norwegian study. *Journal of Nursing Management (Wiley-Blackwell), 13*(3), 221-230. doi:10.1111/j.1365-2834.2004.00527.x.

Benshoff, J. M., Counseling, E. C. o., & Student Services, G. N. C. (1994). *Peer Consultation as a Form of Supervision.* ERIC Digest. In. https://eric.ed.gov/?id=ED372352.

Bond, M., & Holland, S. (2010). *Skills of Clinical Supervision for Nurses. A Practice Guide for Supervisees, Clinical Supervisors and Managers.* Maidenhead: Oxford University Press.

Bordin, E. (1983). A Working Alliance Based Model of Supervision. *The Counseling Psychologist, 11*(35), 35-42. doi:DOI: 10.1177/0011000083111007.

Butterworth, T., Bell, L., Jackson, C., & Pajnkar, M. (2008). Wicked spell or magic bullet? A review of the clinical supervision literature 2001-2007. *Nurse Education Today, 28,* 264-272.

Colthart, I., Duffy, K., Blair, V., & Whyte, L. (2018). Keeping support and clinical supervision on your agenda. *Nurs Manag (Harrow), 25*(5), 20-27. doi:10.7748/nm.2018.e1804.

Crockett, S., & Hays, D. G. (2015). The Influence of Supervisor Multicultural Competence on the Supervisory Working Alliance, Supervisee Counseling Self-Efficacy, and Supervisee Satisfaction With Supervision: A Mediation Model. *Counselor Education & Supervision, 54*(4), 258-273. doi:10.1002/ceas.12025.

Cummins, A. (2009). Clinical supervision: The way forward? A review of the literature. *Nurse Education in Practice, 9,* 215-220.

Cutcliffe, J., Butterworth, T., & Proctor, B. (2001). *Fundamental Themes in Clinical Supervision.* London : Routledge.

Dawber, C. (2013). Reflective practice groups for nurses: A consultation liaison psychiatry nursing initiative: Part 2—The evaluation. *International Journal of Mental Health Nursing, 22(*3), 241-248. doi:10.1111/j.1447-

0349.2012.00841.x.

Department of Health and Human Services. (2018*). Clinical supervision for mental health nurses. A framework for Victoria.* Melbourne: Victorian Government.

Diversity and inclusion HR Policy G2. (G2 (QH-POL-132)). (2016). Queensland: Queensland Government Retrieved from https://www.health.qld.gov.au/__data/assets/pdf_file/0020/396101/qh-pol-132.pdf.

Driscoll, J., Stacey, G., Harrison Dening, K., Boyd, C., & Shaw, T. (2019). Enhancing the quality of clinical supervision in nursing practice. *Nursing Standard, 34*(5), 43-50.

Evans, C., & Marcroft, E. (2015). Clinical supervision in a community setting. *Nursing Times, 111*(22), 16-18.

Gonge, H., & Buus, N. (2016). Exploring Organizational Barriers to Strengthening Clinical Supervision of Psychiatric Nursing Staff: A Longitudinal Controlled Intervention Study. *Issues in Mental Health Nursing, 37*(5), 332-343. doi:10.3109/01612840.2016.1154119.

Hall, I. (2018). Implementing a sustainable clinical supervision model for Isles nurses in Orkney. *British Journal of Community Nursing, 23*(3), 136-139. doi:10.12968/bjcn.2018.23.3.136.

Harvey, S., Spurr, P., Sidebotham, M., & Fenwick, J. (2020). Describing and evaluating a foundational education/training program preparing nurses, midwives and other helping professionals as supervisors of clinical supervision using the Role Development Model. *Nurse Education in Practice, 42,102671*. doi:https://doi.org/10.1016/j.nepr.2019.102671.

Hawkins, H., & Shohet, R. (2012). *Supervision in the Helping Professions.* Maidenhead: Oxford University Press.

Health Education and Training Institute. (2013). *The Superguide: A Supervision Continuum for Nurses and Midwives.* HETI. Sydney.

Kenny, A., & Allenby, A. (2013). Implementing clinical supervision for Australian rural nurses. *Nurse Education in Practice, 13*(3), 165-169. doi:http://dx.doi.org/10.1016/j.nepr.2012.08.009.

Key, S., Marshall, H., & Martin, C. J. H. (2019). The Scottish Clinical Supervision Model for midwives. *British Journal of Midwifery, 27*(10), 655-663. doi:10.12968/bjom.2019.27.10.655.

King, R., & Mullan, G. (2008). Clinical Supervision In C. Lloyd, King, R, Deane, F & Gournay, K. (Ed.), *Clinical Management in Mental Health Services* Chichester West Sussex.: Wiley-Blackwell.

Love, B., Sidebotham, M., Fenwick, J., Harvey, S., & Fairbrother, G. (2017). "Unscrambling what's in your head". A mixed method evaluation of clinical supervision for midwives. *Women and Birth, 30,* 271-281.

Lynch, L., & Happell, B. (2008a). Implementation of clinical supervision in action: Part 2: Implementation and beyond. *International Journal of Mental Health Nursing, 17*, 65-72. doi:10.1111/j.1447-0349.2007.00512.x.

Lynch, L., & Happell, B. (2008b). Implementation of clinical supervision in action: Part 3: The development of a model. *International Journal of Mental Health Nursing, 17*, 73-82. doi:10.1111/j.1447-0349.2007.00513.x.

Martin, P., Kumar, S., & Lizarondo, L. (2017). When I say … clinical supervision. *Medical Education, 51*(9), 890-891. doi:10.1111/medu.13258.

Martin, P., Milne, D. L., & Reiser, R. P. (2018). Peer supervision: International problems and prospects. *Journal of Advanced Nursing, 74*(5), 998-999. doi:10.1111/jan.13413.

Nursing and Midwifery Board of Australia. (2018). *Code of Conduct for Midwives* https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx.

O'Connell, B., Ockerby, C. M., Johnson, S., Smenda, H., & Bucknall, T.R. (2011). Team Clinical supervision in acute Hospital Wards: A Feasability Study. *Western Journal of Nursing Research, 35(*3), 330-347.

Peer Support Program Deployment Guidelines. (2019). Queensland: Queensland Health Retrieved from https://qheps.health.qld.gov.au/__data/assets/pdf_file/0018/2302650/pdg.pdf.

Pettman, H., Loft, N., & Terry, R. (2019). We Deal Here With Grey: Exploring Professional Boundary Development in a Forensic Inpatient Service. *Journal Of Forensic Nursing.* doi:10.1097/JFN.0000000000000250.

Pollock, A., Campbell, P., Deery, R., Fleming, M., Rankin, J., Sloan, G., & Cheyne, H. (2017). A systematic review of evidence relating to clinical supervision for nurses, midwives and allied health professionals. *Journal of Advanced Nursing (John Wiley & Sons, Inc.), 73(*8), 1825-1837. doi:10.1111/jan.13253.

Proctor, B. (2011). Training for the supervision alliance. In J. R. Cutcliffe, K. Hyrkas, & J. Fowler (Eds.), *Routledge Handbook of Clinical supervision, Fundamental International Themes*. New York: Routledge.

Queensland Health. (2009). *Clinical supervision guidelines for mental health services*, October 2009. Brisbane: Queensland Health. Retrieved from https://www.health.qld.gov.au/qcmhl/supervision_res.

Queensland Health. (2018a). *Framework for lifelong learning for nurses and midwives (Queensland Health),* June 2018. Brisbane,QLD: State of Queensland (Queensland Health).

Queensland Health. (2018b). *Nursing Clinical Supervision Procedure Metro North Mental Health*, October 2018. Metro North Hospital and Health Service. Brisbane: Queensland Health. Retrieved from https://qheps.health.qld.gov.au/__data/assets/pdf_file/0018/2302650/pdg.pdf.

Scaife, J. (2001). *Supervision in the Mental Health Professions.* London and New York: Routledge.

Soheilian, S. S., Inman, A. G., Klinger, R. S., Isenberg, D. S., & Kulp, L. E. (2014). Multicultural supervision: supervisees' reflections on culturally competent supervision. *Counselling Psychology Quarterly, 27*(4), 379-392. doi:10.1080/09515070.2014.961408.

The Bouverie Centre, Ryan, S., Wills, M., Whittle, T., & Weir, S. (2013). *Clinical Supervision Guidelines for the Victorian Alcohol and Other Drugs and Community Managed Mental Health Sectors*. Melbourne, Victoria: La Trobe University.

White, E., & Winstanley, J. (2009. Implementation of Clinical Supervision: educational preparation and subsequent diary accounts of the practicalities involved, from an Australian mental health nursing innovation. *Journal of Psychiatric and Mental Health Nursing, 16,* 895-903.

White, E., & Winstanley, J. (2010). A randomized controlled trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing, 15*(2), 151-167.

Ziller, R. C. (1965). Toward a Theory of Open and Closed Groups. *Psychological Bulletin, 64*(3), 164-182.

Queensland Government