CLINICAL SUPERVISION

Rhetoric or Reality?

Janelle Roby (Senior Physiotherapist / Project Officer)
Rebekah Reurich (Senior Social Worker / Project Officer)
Dr Sue Fitzpatrick Executive Director Allied Health, Disability Inclusion & NDIS

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WHAT DO WE ALREADY KNOW?

Increasing body of research has shown significant benefits for staff and organisations.

Clinical supervision (CS) should be individual, flexible, transparent, adequately prepared for.

CS needs to be accessible with clear delineation between supervision and line management, clear expectations and a trusted relationship.

A framework is recommended and protected time.
WHAT DID WE WANT TO KNOW?

What is the experience of clinical supervision actually like for AH staff in the Illawarra Shoalhaven Local Health District?
THE GREAT DIVIDE

Kate vs Josie

Why are these experiences so different?
Action research approach

13 focus groups held across 9 sites (3 rural sites, 4 rural groups)

67 participants from 10 disciplines

Level 1 to 7 ranging from new grad to >25yrs experience

Short questionnaire prior to discussion

Data was recorded in front of participants

Focus groups were approx. 1.5hrs in duration

Sub theming throughout: working well, challenges/areas for improvement, solutions

Theming: overall themes, discipline specific, site specific
RESULTS: QUESTIONNAIRE

The majority agreed or strongly agreed:

- Satisfied with CS frequency, length & quality
- CS is effective & improves practice
- Had a contract
- Were aware of the policy, that it was mandatory & had support from Mx
- Received introduction to CS
- Had training and felt confident in providing CS

The greatest variation in satisfaction related to:
- Documentation
- Supervisor choice
- Feedback

80.6% receive monthly CS
74.6% receive > 45mins
People knew there was a policy and turned up because they saw value in CS but the majority had not read the actual policy!

- How are they learning about CS?
- How are they identifying its value?
- Are policies inaccessible?
- Are they just ticking a box?
- Is clinical supervision reality or rhetoric?
RESULTS: THEMES

- Documentation
- Part time staff
- Informal and Ad Hoc S/V
- Supervision load
- Interdisciplinary S/V
- HETI vs ISLHD
- Flexibility
- Space and equipment availability
- Policy readership and accessibility
- Time/Workload/Prioritisation
- Frequency
- Quality
- Training
- Feedback
- Access to supervisors
- Value of S/V
- CS differences between disciplines
- Choice of supervisor

CULTURE

- People
- Performance
- Process

POLICY
“Walking the walk and talking the talk: knowing the rights and responsibilities on both sides to make it effective”
(Focus Group 2)

“We have a clear model of introducing supervision to new staff – a role in orientation – which is working well”
(Focus Group 4)
“There is no measurement of the quality of supervision - how do we assess quality? “ (Focus Group 7)

“If the quality of supervision is poor, motivation and compliance is reduced” (FG 9)

“When supervision is ineffective, prioritising S/V over clinical work which is already challenging, becomes even harder” (FG 10)

“It can be challenging to provide negative feedback” (FG 11)
Clinical Supervision Contributor Model
Communication

Quality

Value

Equity
CONCLUSION: WHERE TO FROM HERE?
**People**
- Abbreviated version of policy/brochure
- Annual think tank session to progress ideas
- District CS portfolio leader with committee

**Process**
- Amendments to policy (with periods of review)
- Standard orientation to Clinical Supervision
- Advanced supervisor training
- Online module refresher training

**Performance**
- Monthly tips
- Interdisciplinary collaboration
- Manchester Clinical Supervision Scale
- Normalising regular feedback and reporting

**Culture**
- Genuine opportunities to give feedback that leads to action
- Opportunities to share and collaborate on differences and similarities across professions
- Consistent messaging from leaders about the value of clinical supervision.
- Provide opportunities for interprofessional collaboration about clinical supervision.
RHETORIC ➔ REALITY

STOP
COLLABORATE
AND
LISTEN

TAKE YOUR PASSION & MAKE IT HAPPEN
ANY questions?