Embedding clinical supervision in rural and remote contexts—is it worth the effort?

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Background

In 2008, Country Health South Australia Local Health Network (CHSALHN) began a major piece of work about Clinical Supervision, seeking to identify the rationale, structures and processes required to embed a clinical supervision culture amongst public allied health professionals in rural and remote South Australia. Clinical Supervision is defined as:

> a working alliance between practitioners in which they aim to enhance clinical practice, fulfil the goals of the employing organisation and the profession and meet ethical, professional and best practice standards of the organisation and the profession, while providing personal support and encouragement in relation to professional practice.1

Clinical Supervision (CS) is attributed with the ability to reduce burnout, improve job satisfaction and retention of clinicians2, to safeguard professional values and standards1, and to support quality clinical practice4. Clinical Supervision is acknowledged as a critical pillar of clinical governance, and has been an important component of, and major focus for, the CHSALHN Allied Health Directorate for the last four years. The question this paper seeks to answer is, ‘has it been worth all the effort?’

Method

In 2008/2009, CHSALHN developed an AHP Clinical Support Framework and Policy. Informed by the literature, the Clinical Supervision model was designed in consultation with key stakeholders to accommodate the unique challenges of the rural and remote context, including dispersed workforce and predominance of ‘rural generalist’ (broad scope of practice) roles. It fosters reflective practice, is profession specific but not content rich, delivered within a matrix structure (separation of Line Manager and Clinical Supervisor roles) and the majority occurs remotely via telephone.

In 2009, the Framework and Policy were endorsed by Executive, and the requirement for all AHPs to have a formal Clinical Supervision arrangement in place was written into job descriptions. Between 2010 and 2012, a significant investment by CHSALHN saw the implementation of profession specific Clinical Leadership roles with designated responsibility and quarantined time for Clinical Supervision, and the roll out of an extensive training program.

A mixed method evaluation was utilised to assess the effectiveness of the implemented Clinical Supervision structures and processes in achieving desired outcomes. Semi-structured interviews and focus groups were conducted with key stakeholders across CHSALHN to garner their perspectives of the implemented Clinical Supervision structures and processes. Participants were also asked to reflect on barriers and enablers in accessing and participating in clinical supervision. An anonymous online survey, using a validated questionnaire (MCSS-26)5, was conducted to garner allied health professionals perspectives of clinical supervision and its impact.

Key findings

Embedding effective CS in rural and remote contexts requires resource investment, strong and persistent leadership, and extensive stakeholder engagement in the development and implementation of ‘fit for context’ structures and processes. Findings from quantitative and qualitative data indicate widespread support of clinical supervision by key stakeholders. While historically there were opportunities for clinical supervision, much of it was ad hoc, opportunistic and local context driven. The implementation of a formal clinical supervision framework has led to formalised, uniform and consistent clinical supervision for allied health clinicians across CHSALHN. Clinical supervision was
widely recognised as positively impacting on staff morale, confidence and skills, which, over a period of 
time could translate into broader outcomes in terms of improved health service delivery outcomes and 
recruitment and retention. This initiative also identified opportunities for improvement in terms of 
flexibility in the supervision framework, balancing clinical workload with supervision requirements, 
challenges associated with geographical distances, technological limitations and evolving local 
organisational mandates.

References