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Professional support

Clinical Supervision for Allied Health Professionals

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EXECUTIVE SUMMARY

Limited professional support is a recognised problem in rural and remote practice, with consequences for the client, organisation and the individual professional.
Professional support is a strategy for health professionals to participate in a community of practice, to identify with professional norms and standards, and integrate these into practice. Professional support promotes safe and quality health care for clients through this professional development. Professional support is a method for health organisations to promote accountable, quality practice, with health professionals implementing this knowledge and skills in their workplace. This professional support may have other benefits for health organisations, including improved recruitment and retention, and a more satisfied and competent workforce, equipped to meet current and future challenges.

This paper is addresses two components:

Professional support

Professional support relationships come in many shapes and sizes. This section discusses some of the terminology, with an emphasis on clinical supervision.

Clinical supervision project

An outline of the WACHS 2008 Allied Health Clinical Supervision Project is provided, together with the project's outputs and recommendations.

LIST OF PRINCIPLES AND RECOMMENDATIONS

Professional support:

- is essential for professional practice;
- is a type of professional development;
- has benefits for professionals, organisation and clients;
- has contested terminology; and
- can take many forms.

WACHS Allied Health Clinical Supervision is organised within a framework of:

- a formal professional support relationship;
- based on 3 principles; and
- governed by 3 considerations.

A WACHS Allied Health Clinical Supervision relationship:

- is a formal professional support relationship;
- between two or more professionals;
- which is supervisee driven;
- with a supervisor from the same profession, or with a specific skill set desired by the supervisee;
- with confidential content;
- in protected work time; within a safe, nurturing, supportive environment.

The WACHS Allied Health Clinical Supervision Framework is based on principles of:

- a supervisee driven relationship;
- flexible and balanced to meet the needs of the employee and WACHS given the work situation; and
- to a set of minimum standards.

The WACHS Allied Health Clinical Supervision Framework is governed by:

- policy and guideline documents;
- coordination with other WACHS systems; and
- training and education in clinical supervision.

1.0 INTRODUCTION

1.1 Identified need for PS

WA Country Health Service (WACHS) allied health professionals (AHPs) frequently work in sole practice, or in small multidisciplinary teams, operating across a broad scope of their profession's practice. Many WACHS AHPs are not line managed by managers from their profession. They are required to function across the continuum of care, from primary to tertiary health care, from hospital to community settings. Much rural and remote practice requires models of service delivery different from metropolitan settings, with frequent change and adaptation. All of this activity occurs under pressure, with high demand for limited resources. These resources are further stretched, and organisational knowledge lost, by substantial staff turnover.

AHPs are highly trained, but much of that training is delivered in metropolitan settings, with specialised content in a metropolitan context. Professional development events largely reflect this same bias. WACHS AHPs clearly require professional development to:

- Maintain and improve a broad range of profession specific knowledge and skills
- Adapt and apply this knowledge and skills in a rural or remote WACHS context
- Manage and cope with the pressures evident in this form of practice

Professional support relationships are one strategy to contribute to this professional development.

1.2 Identified benefits of PS

Professional support can provide a range of potential direct and indirect benefits to both WACHS and individual professionals, and their clients. For example, clients may benefit from safer, more effective health care from more consistency of practice, and increased perfusion of best practice concepts and innovation amongst health professionals.

WACHS benefits of professional support - safety and quality focus

WACHS has a variety of commitments to the community and their employees. Safety and quality of health care is a current imperative across much of the developed world, with acknowledged requirement for changes in organisational culture and a systems approach to

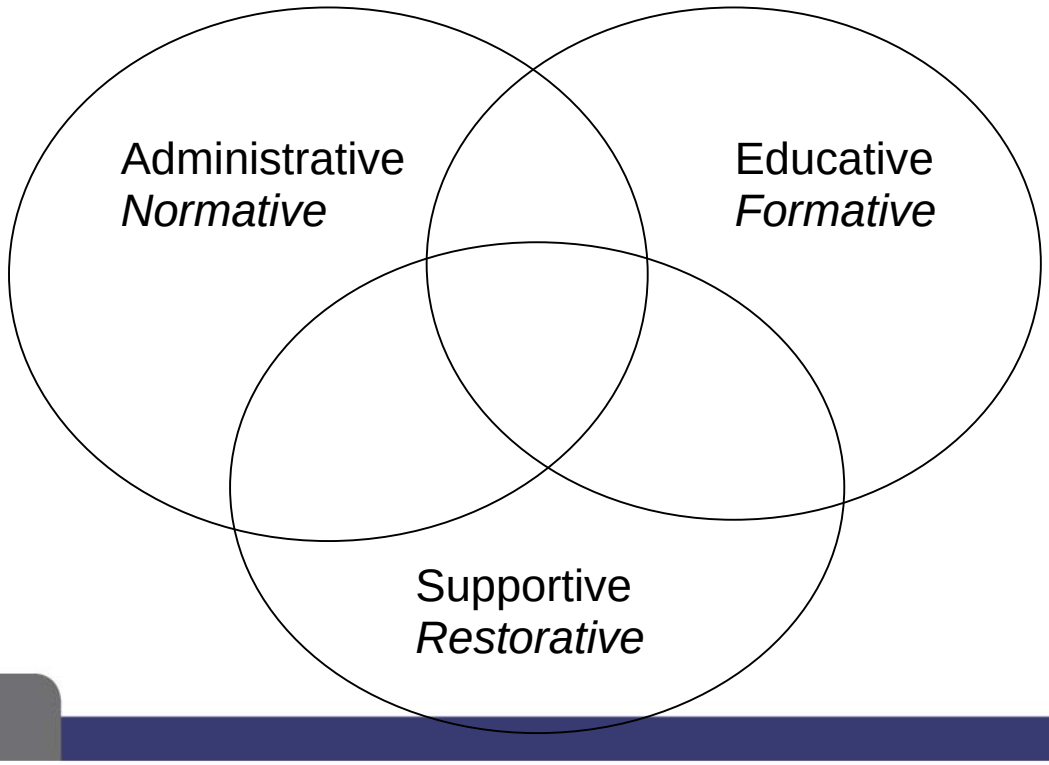
identifying risks (Currie and Watterson, 2007). These systems include risk management, professional development and support. Health care issues and service models that are relatively frequent and consistent may benefit from standardised care pathways. For much of the health care delivered by WACHS AHPs, these have not been developed. Organisational efforts to promote professional development and support are evidence promoting safe, quality health care for the community.

WACHS may also benefit from professional support via recruitment and retention, and occupational safety and health duties of care. Rural and remote AHP recruitment and retention has been demonstrated as reduced by limited access to professional development, and professional isolation. Staff burnout has also been implicated with reduced professional support.

An important but relatively recent concept is that of a community of practice. This concept invokes a number of the key elements suggestive of a community within a profession setting, such as norms of behaviour, and the application of community development principles. Many professional support systems promote a community of practice, which is a concept that may particularly benefit geographically and professionally isolated professionals like WACHS AHPs. A community of practice adds value to WACHS, by increasing employee knowledge and support, as well as promoting innovative but safe practice.

Functions of Supervision

Individual AHPs benefits of professional support – Kadushin's and Proctor's models



WACHS AHPs have to deal with the many workplace issues outlined earlier in this introduction section. Potential benefits of professional support relationships may be considered using Kadushin's Functions of Supervision to distinguish some elements of practice.

Educative elements include knowledge and skills in health care delivery, relevant to the specific profession, multidisciplinary, or rural and remote setting. Many forms of professional development may provide this knowledge and skills, but professional support relationships provide and opportunity to reflect on current practice, and adapt and apply this knowledge to improve current practice. This form of professional support may also include understanding limits and boundaries to acceptable practice.

Administrative elements include operating within the WACHS organisation, and managing the workload, such as prioritisation and alternative models of healthcare delivery.

Supportive elements include coping with work pressures, particular personalities. Professional support may improve understanding of these elements, learning to adjust practice, and maintain personal safety.

These elements in this model have significant overlap. The Functions model serves as a tool to recognise many of the aspects of work that may require attention. Educative functions are emphasised in many forms of professional development, although there exist questions regarding the effect of these forms of professional development in modifying practice. Although effective managers may consider the many elements of work, administrative functions are the focus of line management relationships. Support functions have been acknowledged as poorly addressed by many Australian managers, and have been suggested in nursing as some of the most important advantages of clinical supervision (Butterworth et al, 2008). Professional support relationships may be principal method of addressing support issues, and are potentially effective in the other functions, to personally reflect on, understand, explore and modify work practice.

2.0 CONCEPTUALISING PROFESSIONAL SUPPORT

Professional support in health care and other industries is a complex area, with continuously evolving terminology. This section will outline a few of these terms, and their possible application within WACHS.

Figure 1
WACHS Allied health professionals professional support system examples

WACHS
Senior profession networks
Line management
New graduate programs

Professions
Professional associations
- Rural / remote special interest groups
Rural and remote health associations
- SARRAH

Individual
Professional networks
- peers
- previous supervisors

Some valuable current professional support mechanisms are listed in Figure 1. Many of these systems provide opportunities to network with other professionals, to learn new knowledge and skills, debrief on practice issues, etc. Many of these systems may be too general in nature, and limited in their capacity to address individual AHPs issues. People within these systems may be, or provide knowledge of, suitable people to provide more specific professional support.

More specific examples of potential professional support relationships include mentoring, coaching, preceptoring and clinical or professional supervision. Definitions of these terms are often contested, having evolved from a clear, traditional understanding to have varied meaning. An outline of these terms is suggested below.

2.1 Mentoring

Classical or traditional mentoring has been a recognised relationship for centuries, characterised as a lifelong relationship between an older, more experienced mentor providing support to a younger, less experienced protégé or mentee. This form of mentoring had a life development perspective, and has been adapted to work mentoring in business organisations. Work mentoring occurs with a more experienced mentor often higher in the organisational hierarchy, providing support to a less experienced mentee. This form of mentoring may be formal, with the relationship often determined by the organisation, or informally developed from an existing interaction. More recently, mentoring is promoted by some health care professions and organisations as a professional support relationship. Whether the emphasis of this health care mentoring can be on current work, career development, personal growth, or all three is unclear. In nursing, this professional mentoring

has been considered similar to clinical supervision as a longer term relationship for increasing knowledge and skills, and professional socialisation. Some differences include occuring outside of work time or work site, and career progression as an area of interest (Mills et al, 2008).

2.2 Coaching

Coaching is often traditionally viewed from a sporting perspective, with a coach guiding, managing and providing development to a team or individual. Coaching as an industry has undergone substantial growth in North America, with terms particularly in business such as professional, executive and life coaching. These forms of coaching suggest the coach is not necessarily an expert in the area being addressed, but rather provides coaching expertise, including facilitation to “explore and address real-life challenges (Byrne, 2007). This contrasts with some usage in health care, where coaching is often a term applied to specific skill or task development. This is sometimes referred to as on-the-job coaching, or skill coaching, common characteristics including short term performance focus, and specific skill development (D’Abate et al, 2003).

2.3 Preceptoring

Preceptoring has been regularly used in nursing literature, succinctly described by Mills et al (2008) as a method of preparation for practice for new practitioners using clinical staff. It is formal, short term, often part of a formalised program such as undergraduate or graduate programs, or for new staff.

2.4 Clinical supervision

Supervision, literally meaning “over see”, developed from industry, where technical skill and task completion was supervised, often by a person with recognised more experience or expertise. Trade apprenticeships may have origins in this form of supervision.

Clinical supervision has evolved in health care from different perspectives, and has different usage in different countries and professions. This may be broadly suggested as medical and social approaches.

The medical approach to clinical supervision has origins in surgery, where a surgical expert supervised an inexperienced person perform the surgery, and determined their competence to perform independently. This approach to clinical supervision is common in North America,

and is used in professions such as physiotherapy, where clinical supervision is considered expert determination of competence, and is often used as synonymous with student supervision. The medical approach to clinical supervision has much similarity with skill or task coaching.

The social approach to clinical supervision has developed in counselling professions, such as psychology, psychotherapy and social work. Counselling professions deal with less physically concrete issues, acknowledging many potential strategies within the therapist – client relationship, which are evaluated for benefit and associated risks. These professions apply clinical supervision in a similar way, suggesting the clinical supervision relationship may address many elements of practice, which are developed within the relationship. Safety, including confidentiality and power differential considerations, are important elements of this clinical supervision relationship. Evaluation is present within this relationship, as the supervisee reflects on practice, considers issues together with the supervisor, who provides guidance. Clinical supervision is often used synonymously with professional supervision in social work. In psychology, clinical supervision by a clinical psychologist is a regulatory requirement. This social approach to clinical supervision may have similarity with work mentoring in other health professions.

2.5 Line management versus clinical supervision

In a hierarchy such as WACHS, every employee has a line manager, who is organisationally accountable for the employee's performance. This accountability can be difficult to clarify, particularly where a line manager is from the same profession as the employee.

Line managers from the same profession may have clinical supervision responsibilities from the medical approach, with evaluation of educative and administrative professional elements. Professional support is often valuable when provided by a line manager, but is limited by a number of factors. These factors include the power differential between the employee and employer, and the difficulty of protecting time for support from organisational issues.

3.0 WACHS ALLIED HEALTH CLINICAL SUPERVISION PROJECT

3.1 Development of WACHS Professional support – Clinical supervision

Project overview

The recognised need for WACHS AHP professional support to promote the safety and quality of health care resulted in funding of a senior project officer 0.6 FTE for six months to develop a clinical supervision framework. The project activity broadly consisted of:

- Literature review
- Development of a clinical supervision framework, including:
    - draft WACHS Policy and Guidelines
    - a training package
- Implementation recommendations

This project activity was supported through the creation of the WACHS Allied Health Clinical Supervision Working Group – which consisted of a number of allied health professionals from various professions across WACHS.

Project scope

The scope of the project was limited to WACHS allied health professions of audiology, dietetics, health promotion, occupational therapy, physiotherapy, podiatry, speech pathology and social work.

Allied health professions employed in Mental Health and Aged Care directorates were considered outside the project scope. It is recognised that professionals in these directorates have professional support needs, but Mental Health have an existing clinical supervision framework, and Aged Care have a different management stream to that implementing the project.

Brief overview of the literature

A review of the literature contributed to the professional support conceptualisation as outlined previously, as the terminology is highly variable between professions and continents. The strong history of the social approach to clinical supervision in the counselling professions was clear, as was the growth of mentoring as a term describing professional support in professions such as occupational therapy. The clinical supervision literature is dominated by the social approach. Medical oriented approaches to clinical supervision of professions such as physiotherapy and podiatry were evident, particularly as a term for student supervision. This approach was also present in ensuring competency to practice, such as with professionals with overseas qualifications, or with audiologists and clinical psychologists to attain registration.

The past 10 years have seen increased interest in clinical supervision particularly in nursing literature throughout Europe. This literature has a marked mental health nursing persuasion, which has continued the social, counselling emphasis. The National Health Service and other United Kingdom sources have contributed greatly to the recent clinical supervision grey literature, predominantly utilising a social approach, although with some varied utilisation of line managers as clinical supervisors. Much of the National Health Service documentation describes their clinical supervision policies in terms of accountability for clinical governance, which may be particularly pertinent given contemporary Australian and WACHS interest in this area..

Consideration during this project was made to other current developments in professional support frameworks. The WA Department of Health Child and Community Health Policy Unit were developing a supervision policy, and the Northern Territory were developing a Professional Practice, Supervision and Support system.

3.2 Allied Health Clinical Supervision Working Group

Professional support terminology

Upon creation of this working group, the different conceptualisation of professional support terminology was apparent. Generally, social workers identified with clinical or professional supervision, which speech pathologists and occupational therapists often considered mentoring. Mentoring was variously considered as formal and informal, work and personal mentoring. Physiotherapists and medical imaging technologists considered clinical

supervision as student supervision. If prompted otherwise, these professionals tended to conceptualise clinical supervision as learning specific skills from an expert, the medical approach to clinical supervision, perhaps suggestive of the physically concrete nature of many of their areas of practice and the approach experienced as a student.

Total agreement on terminology did not occur, which was expected given the different usage. Rather than developing a new term such as the case in the Northern Territory, it was decided to proceed with one that is common and current in the literature, although contested.

Professional support requirements

Regardless of the terminology applied, when considering professional support relationships some characteristics were commonly desired. These characteristics included that the professional support relationship:

- Should be driven by the employee. This included selection of supervisor, and relationship content.
- Should not be with the line manager. This was not reducing the value of a line manager of the same profession, but highlighted the limitations of the hierarchical relationship in providing support. This has been found previously across professions as an important factor (Cutcliffe and Hyrkas, 2006), as has the confidential nature of the specific content.
- Should be supported by WACHS. This support should included protected work time, and consideration to funding.
- Should be integrated into WACHS systems and processes.

The characteristics above, and many of the other common suggestions included in the WACHS Allied Health Clinical Supervision Policy documents, were highly consistent with the social approach to clinical supervision. Clinical supervision was considered the preferred terminology, utilising a social approach. The actual content of the medical approach to clinical supervision is a subset of the social approach. AHPs desiring more skill specific clinical supervision could still receive that content from an expert, with the difference being that they were responsible for driving the relationship, instead of the expert.

Whether termed clinical supervision, professional supervision, mentoring, or even in some instances coaching, the professional support relationship desired by these professionals underlying the different terminology was reasonably consistent.

Shared language

In the interests of a shared language, the remainder of this document refers to clinical supervision as the preferred term, and the participants as clinical supervisor and clinical supervisee.

Individual cases of AHPs prefering to call participants coach, mentor, professional supporter and the like, would not detract from, or diminish the value of the professional support relationship characteristics which underpin the WACHS clinical supervision framework for allied health professionals. It is the professional support that is central, not the terminology which may undergo further transformation in health care in the future.

3.3 Implementation

Implementation of professional support relationships such as clinical supervision within organisations has been limited in many circumstances due to a range of factors. This limitation has led to the development of implementation models for clinical supervision in nursing, such as the Lynch (Lynch and Happell, 2008) and Driscoll (2007) models. These models essentially suggest an organisational needs assessment, formation of ideas for implementation, planning and operationalising, and evaluation (Lynch and Happell, 2008).

3.4 Professional support needs assessment

Anecdotal evidence of WACHS allied health needs was developed from shared experiences of a number of allied health project officers. These needs were explored with the working group, with the following major areas identified.

Allied health need professional support

The WACHS organisational culture for allied health professionals was one largely of sole practice or small teams, multidisciplinary requirements, with broad knowledge pressures, and limited engagement with the WACHS organisation beyond the local setting. As outlined previously, professional isolation and limited professional support were often characteristics

of WACHS allied health practice, indicating a need for professional support as suggested by the development of this project.

The conceptualisation of this support varied, mainly by profession rather than work setting. With prompting, the general consensus was that professional support other than line manager, determined by the employee, in work time was desired. Conceptually this was most aligned with literature descriptions of clinical supervision, as opposed to professional mentoring which has been viewed as occurring in the individual's own time (Mills et al, 2005).

There was some disagreement over clinical supervision as a term, due to the different conceptualisation outlined previously. The generally agreed professional support characteristics above, were considered as clinical or professional supervision by social workers, and mentoring by other professions.

Allied health needs varied by different professions

There were also some difference in the particular support arrangements desired, again principally between professions. Generally, social workers desired clinical supervision from a social approach, with clinical supervisors experienced and trained in this approach. These supervisors were often considered more available external to WACHS. Occupational therapists and physiotherapists viewed the professional support as an alliance with a clinical expert, often seen as a metropolitan specialist.

3.5 Ideas for implementation of clinical supervision

The above suggests there is a need within allied health for education on various professional support relationships. This education includes:

- Knowledge and understanding of the different terms and conceptualisations
- Benefits of the various professional support relationships

There is also a need for improved acknowledgement of WACHS capacity to provide both clinical experts within a rural and remote context, and people with clinical supervision skills. This may be facilitated by allied health and clinical supervisor registers, and use of strategies such as awards and newsletters to recognise allied health professional achievements. The

engagement of allied health with the WACHS organisation may also be improved by these types of mechanisms.

Management support for the concept was considered vital for successful implementation, which has been identified as a barrier to implementation elsewhere ((Lynch and Happell, 2008). This led to the development of the draft Allied Health Clinical Supervision Policy and Guidelines. Integration of clinical supervision with other WACHS systems and processes was also considered important.

3.6 Recommendations – implementation of WACHS allied health clinical supervision

The five implementation recommendations for allied health clinical supervision consist of the following.

1. ***Endorsement of the WACHS Allied Health Clinical Supervision Policy and Guidelines***

The clinical supervision framework has been developed, and a final draft of policy documents completed by the working group. These present clear guidelines for the application of clinical supervision for WACHS AHPs, which still require review by the WACHS Allied Health Reference Group, Population Health Managers, and Executive committees before endorsement.

2. ***Education regarding professional support including clinical supervision for WACHS Allied Health Professionals***

The working group intiative commenced this process, with the twenty members of the working group having been exposed to the concept. An initial 90 minute videoconference to approximately 20 allied health participants at seven WACHS sites was provided, with the powerpoint available as a resource.

Following successful policy endorsement, a Clinical Supervision web page on the WACHS Intranet would be created, with supporting documents. The project officer will continue to engage with the WACHS allied health profession networks regarding professional support.

3. Integration of professional support including clinical supervision into current WACHS systems and processes

The WACHS systems and processes identified for integration with professional support consisted of:

- Recruitment and selection
- Orientation and induction
- Performance development
- Line management

Professionals undergoing recruitment, orientation and induction systems were considered to require education on professional support including clinical supervision. This could be delivered via an intranet page, or a pamphlet.

Clinical supervision is one strategy available to meet certain performance development objectives, and should be considered within this process. Area office Learning and Development Unit have included clinical supervision in the proposed performance development planning documentation.

There were anecdotal concerns raised regarding the overall level of engagement in performance development in the WACHS allied health workforce. This may require further attention. Line managers should engage staff in performance development, and the potential use of clinical supervision as a strategy considered.

4. Training in clinical supervision

Education regarding professional support has been previously mentioned. Further training is proposed to facilitate effective engagement in clinical supervision. This training would consist of skills for effective clinical supervision development and participation, as a clinical supervisor or supervisee.

A draft Clinical Supervision training manual has been developed, for further refinement by allied health project officers as part of a suite of proposed supervision training modules. This training package could be provided in different media; as a self-directed learning package, via videoconference or onsite.

5. Resources for engaging in clinical supervision

There are currently external training packages in supervision, such as Family Partnership Approach, which is a form of social approach clinical supervision. Rick Ladyshewsky's Clinical Supervision modules, which are for student supervision training, cover many of the concepts essential to clinical supervision. Support should continue for utilisation of these resources where possible.

A recommendation for further consideration was the development of a WACHS wide list of clinical supervisors, including their level of experience, areas of interest, expertise and training in clinical supervision. No person could be identified to be responsible for the development and maintenance of such a database. This recommendation was countered with a suggestion that profession specific networks could undertake this task, but this limits professional support scope to potential supervisors of the same discipline. This situation highlights the limited identification of WACHS AHPs as a collective identity, and a potential need for organisation structures to assist with identification in this diverse workforce.

3.7 Evaluation of clinical supervision implementation

Evaluation of clinical supervision and other professional support mechanisms amongst WACHS allied health professionals is necessary. Uptake of clinical supervision would be evident via collation of individual relationship contracts, but the person to perform this has not been identified.

The project officer is developing a pilot allied health professional development survey as a postgraduate university course requirement. This survey would establish a baseline of current professional development activity, including clinical supervision and mentoring.

It is recommended that an abridged version of this survey be undertaken in 12 – 18 months.

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