SA HEALTH

Allied Health Clinical Supervision Framework

March 2014

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Acknowledgements

This framework is adapted from a range of supervision resources and guidelines, including but not limited to:

- Country Health SA Allied and Scientific Health Clinical Support Framework (Oct 2012).
- The Superguide – A handbook for supervising allied health professionals (2012), Health Education and Training Institute, NSW.
- Southern Adelaide Local Health Network Allied Health Clinical Supervision Framework (Sept 2013).
- Women's & Children's Health Network Clinical Supervision (draft)
- Southern Primary Health Clinical Supervision Guidelines and Procedures (May 2012).
- Adelaide Metro Mental Health Directorate Clinical Supervision Framework (May 2012).

The Allied & Scientific Health Office would like to acknowledge the generous contributions made by allied health staff within and across SAHLN, CHSALHN and WCHN sites in the development of this framework.

1. Introduction & Purpose

This framework outlines SA Health's commitment to supporting Allied Health Professionals (AHPs) working within their Local Health Network (LHN) in accessing consistent, appropriate and effective clinical supervision and support mechanisms.

Clinical Supervision is "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations" (Marais-Styndom 1999). It utilises critical conversations to provide formative, supportive and normative elements such as developing potential, harmonious working relationships and good standards of work (HETI 2012).

Supervision of clinicians has been identified as a national priority by Health Workforce Australia (HWA) as evidenced through the development of a National Clinical Supervision Support Framework and the Clinical Supervision Support Program (HWA 2011a; HWA 2011b).

SA Health is committed to improving the safety and quality of healthcare through clinical governance and enhanced clinical effectiveness. SA Health recognises the importance of clinical support to AHPs in the development of high quality and safe practice and acknowledges this is one of the essential components to ensure effective clinical governance. All SA Health allied health staff and senior management have a responsibility to ensure that high quality clinical supervision is occurring for all AHP staff in a culturally safe and respectful manner.

SA Health will ensure clinical support for AHP staff that is:

- Flexible, balancing the needs of the organisation and the individual in terms of access, process and delivery methods.
- Inclusive of a range of support mechanisms including clinical supervision.
- Adequate in meeting the minimum standards set out by governing professional bodies and boards and existing professional competency standards.
- Linked to performance development and review process and embedded in job and person specifications.

This document should be read in conjunction with the Allied and Scientific Health Clinical Governance document which provides an overarching framework for clinical governance within SA Health.

2. Applicability / Target Audience

This clinical supervision framework has been developed for use by the following individuals in an effort to describe and improve the standards and consistency of clinical supervision for allied health working in SA Health

- Allied health professionals
- Managers / team leaders of AHPs
- Health service managers
- Allied health directors
- Allied health educators
- LHN Executives and Boards

3. Outcomes

- All AHP staff will access the clinical supervision they require with endorsement and support from their health units.
- There will be a consistent approach to clinical supervision applied to all AHP staff in SA Health
- Supervisors and supervisees will feel adequately supported in their roles with clear roles and responsibilities.
- Supervisors will have access to clinical supervision training and support to fulfil supervision roles.
- Clinicians will be supported to utilise an evidence based approach in their clinical roles.
- Clinical supervision and support across LHNs will be monitored and evaluated to ensure the needs of AHPs are met.

4. Principles of Supervision

The following principles are supported by SA Health to ensure clinical supervision is effective:

- Clinical supervision utilises a proactive approach to support clinicians in their practice.
- Clinical supervision will promote a reflective approach to clinical practice.

5. Minimum Standards

For clinical supervision to be effective, the following components are considered minimum standards for every AHP within SA Health:

- Every individual AHP employed will have a nominated clinical supervisor.
- Every AHP will have an individual Supervision Agreement developed, by negotiation, between the supervisee and supervisor.
- An individual supervision agreement will be developed that clearly outlines the following:
  - The roles and responsibilities of the supervisor, supervisee and any other key individuals involved in the plan.
  - Expectations of the supervisory relationship, process, methods, and frequency.
  - The supervision needs and goals of the supervisee, including individual learning styles.
  - The agreed supervision methods that will be employed to address the goals.
  - The frequency and duration of supervision meetings and activities.
  - Appendix 1 contains an example of a Supervision Agreement; however other agreements are acceptable as a record such as those from professional associations.
- Supervision sessions and activities will be documented as demonstrated by the maintenance of a supervision log and documentation. See Appendix 2 & 3.
- The Supervision Agreement should be reviewed regularly as needs or circumstances change.
- Confidentiality within supervision will be discussed, including limits to confidentiality, negotiable and non-negotiable matters and circumstances.

Supervision Agreement

When developing the agreement a review time should be set to give both parties the opportunity to discuss how the supervision relationship is going, the need for any changes, and a review of goals and to plan for the future. The review should be scheduled regularly as needs or circumstances change. This is to ensure supervision is meeting both the supervisee's and supervisor's needs.

It is essential that supervision goals consider the role of the supervisee, their current skills, and experience and competency level to undertake key aspects of their role and may also consider specific requirements of supervision as dictated by individual registering or accrediting AHP bodies. Methods of supervision will need to meet the specific supervision requirements and goals of the individual and may be provided via a combination of methods within the constraints of the organisational structure and resources.

An agreed process (a preventative plan) can be negotiated in the supervision agreement, should the issue of conflict become apparent. In the first instance, it is suggested that both participants make every effort to resolve issues themselves. A supervisor may discuss difficulties that arise in supervision with their own supervisor. Where issues are not able to be resolved, it is appropriate to use an agreed mediator, (usually a senior colleague), to mediate the discussions. See Appendix 1.

Documentation

Documentation is an important aspect of clinical supervision and aims to promote accountability of actions, decisions and plans and enabling consistency from one session to the next. For most health units, documentation will need to be stored centrally for seven (7) years after the relationship is terminated. The content of notes taken should also be discussed at the outset including: the level of detail recorded, client identifying information, acronyms or codes to be used etc.

Many professional associations and registration boards now require a supervision log to be kept in order to evidence the existence of clinical support. Line managers may also like to review the supervision log intermittently as negotiated with the supervisee, as well as a summary of outcomes from time to time to improve accountability. See Appendix 2 & 3.

Confidentiality

Confidentiality in the supervisory relationship is a vital aspect of clinical supervision. It protects clients' personal information, clinician integrity and any sensitive information that may be raised. Confidentiality is governed by the organisational confidentiality policy and clinicians' codes of conduct, and is limited by legal and mandatory reporting requirements and breaches of duty of care. Where information is divulged during supervision that raises concern for the supervisor these concerns will be discussed with the clinician and brought to the attention of the line manager as outlined in the supervision contract.

In order to maintain confidentiality the following is required:

- Discussion about how confidentiality will be managed within supervision, including negotiable and non-negotiable matters and circumstances. Organisational and professional body's confidentiality policies and professional codes of conduct may be consulted for specific information and rules. It is mandatory that the supervisor discusses with the supervisee any potential breach of policy / code of conduct and documents any actions to be taken.
- Ensuring that the details of clinical supervision discussions remain confidential with the following exceptions:
  - Clinical supervision reveals that there is an issue relating to duty of care to the client or the staff member. The clinical supervisor is then required to follow specific reporting procedures established by the organisation or professional body,
  - The line/program manager has duty of care concerns and is required to consult with the clinical supervisor,
  - organisational policy and / or professional code of conduct has been breached and there is a requirement to report,

- information for processes such as Professional Review and Development Plan, Credentialing and Scope of Practice are provided with permission from both parties,
- The clinical supervisor's own supervision, where the supervisee remains anonymous.

- Ensuring that discussion and documentation of client related issues remains non-identified in the clinical supervision record e.g. client initials only and not UR number
- Concealment of the client, family and associated parties' personal details when a clinician undertakes professional training or clinical supervision with those not employed by SA Health.

A checklist is provided in Appendix 3 to assist in ensuring all of the minimum standards have been met for each allied health professional.

6. Method and Frequency of Clinical Supervision

Clinical support and supervision may include a range of different methods (refer to Appendix 6).

It is important to be aware that different minimum standards of clinical supervision exist within individual organisations and for specific allied health professionals that are determined by national accrediting bodies and associations. Where possible, these standards have been incorporated into this document; however it is the responsibility of the supervisor and supervisee to ensure that the methods, frequency and duration of supervision meet these standards.

A recent literature review conducted by the International Centre for Allied Health Evidence (iCAHE), on behalf of Allied Scientific and Health Office revealed limited high level evidence regarding the method and frequency of clinical supervision (University of South Australia 2013). The amount of time required for clinical supervision may vary across clinicians. This depends on the clinician's level of competence, years of experience, type of clinical experiences, learning style, and other factors. It is acknowledged that some AHPs will need more support than others and this should be accommodated where possible to ensure clinicians feel confident and supported in their work roles.

The following table is recommended by the Allied and Scientific Office in conjunction with the State-wide Allied Health Executive Group as the minimum frequency for clinical supervision for allied health professional staff employed within SA Health.

Clinician	Minimum Amount of Time Required*	Comments for Manager
New Graduate / Base Grade Clinician	4 hours/month initially (reducing over time)	If not participating in graduate year activities, implementation of clinical support is essential- the transition from student to professional is a critical time. It is recommended that supervision time will be focused on 1:1 structured supervision Need to consider previous relevant experience (e.g. student placements, participation in graduate program, number of years already in the workforce).
Experienced AHPs	1 hour/4-6 weeks	Hours may be increased in circumstances requiring acquisition of a new skill area (e.g.: beginning to specialise) or moving into new work setting.
Locum/Temporary	4 hours/month	Select suitable supervisor or mentor during recruitment process to ensure clinical support can be implemented

employees		as quickly and easily as possible.
Clinicians in clinical support roles i.e. health promotion, service development, project roles	1 hour/1-2 month	Supervision will vary according to the clinician's experience in their work role and the complexity of the role. Supervision may be provided by another profession where appropriate or according to the needs of the supervisee.

Hours may be adjusted on a pro-rata basis for part-time employees as negotiated with the manager depending on hours worked, clinical roles and responsibilities and **needs of the clinician.* It should be noted that the minimum time requirement for supervision hours may be distributed across a range of different methods as negotiated in the development of the supervision agreement and may be cumulative.

Clinical supervision can be provided by senior clinicians, professional leads, line managers, service managers, team leaders, peers and external supervisors. Deciding who provides clinical supervision depends on the context, the professional needs of the supervisee, availability of suitable supervisors and the needs of the organisation.

For AHPs in interdisciplinary or non-profession specific roles, consideration will need to be given to how the individual will access profession specific supervision in order to maintain credentialing status as an AHP within SA Health (see Policy Directive: Authenticating Allied Health Professionals Credentials Policy including Access Appointments.
http://www.health.sa.gov.au/Portals/0/ASHO_Credentialing%20Policy%202013%20Final.pdf). If there is not an appropriately qualified supervisor within the same profession available within the immediate team/unit then access to a suitable colleague within the same profession outside of the individual's team/department may need to be considered as part of the supervision plan.

It is acknowledged that experienced AHPs working in senior clinical speciality and management positions may find it difficult to access suitable clinical supervisors within their LHN. For AHPs in these roles, it may be appropriate to consider nominating an external supervisor or adopting a mentoring approach as the primary means of supporting continued growth and development. It is the joint responsibility of the line manager and professional lead and the individual AHP staff to ensure that an appropriate supervision plan and method is negotiated and implemented.

7. Differentiation of Clinical Supervision, Line Management, and Mentoring

Supervision includes formative (educational), restorative (supportive) and normative (administrative) functions and should incorporate a reflective practice approach (HETI 2012). While all three functions are important to support the growth and development of the AHP, these functions may be delivered via a combination of clinical supervision and line management functions.

The literature supports that it is preferable to separate clinical supervision and mentoring from line management due to the inherent power imbalances that exist within a line management relationship (Smith 2005). This is not always achievable within existing department and team structures. There is diversity of organisational and team structures in operation across SA Health, and there is no single method of supervision which would adequately cover the diverse nature and needs of AHPs working within these structures. Consequently, it is the intention of this framework to identify a range of effective supervision methods which can be selected in any combination in order to meet the needs of the individual.

Whilst supervision and management functions may be delivered separately in some structures, they are both important and are complementary. The following table distinguishes line management, supervision and mentoring roles and responsibilities.

Clinical Supervision	Operational Line Management	Mentoring
Driven by the clinical development needs of the clinician	Driven by service delivery, team and individual development needs and requirements.	Deliberate matching of two clinicians, one generally with more experience than the other.
Targeted to promote enhanced client outcomes and safety	Manages performance	Focusses on the growth and career development of the mentee through supporting, guiding, advising
Teaches and facilitates best practice knowledge and skills acquisition in clinical practice and guides professional development needs	Manages human resource issues such as staff development, mandatory training and annual leave	Supports skill and knowledge acquisition through reflection and assistance to develop plans to achieve goals
Provides a forum for discussion of ethical practice issues	Allocates and monitors workload or caseload proactively in collaboration with the clinician and supervisor	Regular dialogue on a range of issues selected by the mentee
Promotes reflective practice	May promote reflective practice in context of service delivery needs	Promotes reflective practice and personal appraisal
Supervisor typically involved in day-to-day work of clinician	Manager involved in day-to-day work of the clinician	The mentor not involved in day-to-day work of the clinician
Formal process	Formal process	Voluntary process

8. Roles & Responsibilities

Role of Supervisor

The role of the supervisor is to participate in the development of the individual supervision plan, and to engage in a system of on-going supervision with the supervisee as agreed in the plan. The supervisor promotes the use of evidence-based practice, reflective practice, observed practice and opportunities for skill development. The supervisor provides regular and specific feedback that reinforces learning and draws attention to aspects of work that need further development. The supervisor ensures appropriate confidential records of supervision activities are maintained.

In addition, it is important that the supervisor is aware of policies, procedures and practices of the supervisee's workplace and team, and demonstrates a commitment to updating their own knowledge and professional skills. The supervisor and supervisee advises the line manager/professional lead* of any performance or ethical issues and mandatory reportable issues.

Role of Supervisee

All AHP staff are expected to actively participate in clinical supervision. Clinicians collaborate with their line manager to ensure an appropriate supervisor is identified and a supervision plan initiated. Supervisees participate in the development of individual supervision plans and assist in identifying appropriate supervision methods to meet their supervision needs.

Clinicians are expected to participate fully in agreed supervision activities and to commit to action agreed to at the conclusion of each supervisory session. The supervisee is encouraged to provide feedback to the supervisor.

Role of Line Manager / Professional Lead*

The Line Manager ensures all of their AHP staff have access to clinical supervision. The Line Manager must ensure an appropriate supervisor is nominated for every AHP within the team, that a negotiated supervision agreement is in place for each AHP, and that regular supervision occurs according to the agreed plan. If issues relating to performance, ethical issues or mandatory reportable issues are raised by the supervisor the Line Manager is responsible for ensuring appropriate performance management processes are implemented or action taken according to relevant policies, directives and legislative requirements.

roles & responsibilities of professional lead may vary between work unit, service and/or LHN.

Role of Senior Management

Senior Management is responsible for providing support and resources to ensure clinical supervision is implemented.

9. Clinical Supervision Training

Providing and receiving clinical support is not an inherent skill; it is not appropriate to assume that good clinicians automatically make good supervisors or that clinicians know how to get the most out of their clinical support sessions.

Training in clinical supervision mechanisms has many benefits including:

- Improving satisfaction for all those involved
- Improving outcomes from clinical supervision
- Improving consistency of support available across SA Health
- Improving quality and safety outcomes for clients
- Increasing the priority of clinical support

Training should be available to all staff involved in clinical support and may occur at a number of levels. Training offered will depend on available resources and programs offered internally and externally at each LHN. Online training modules in collaboration with ASHO are available for all supervisees and supervisors which will provide SA Health AHP staff with a readily accessible means of training in supervision.

10. Evaluation & Monitoring

Clinical Supervision Framework

The LHN Allied Health Directors will have overall responsibility for evaluation and monitoring of this framework.

The framework will be monitored for compliance by the following:

- 100% of AHP staff will have a Clinical Supervision Agreement in place within 6 months of commencing their employment, audited on an annual basis
- 100% of AHP staff will have an allocated clinical supervisor in place within 6 months of commencing their employment, audited on an annual basis
- 100% of AHP staff will have a Supervision Log in place, audited on an annual basis.
- Evaluation of the framework will include seeking feedback from both supervisors and supervisees.

Individual Supervision Arrangements

The quality of individual clinical supervision arrangements should also be regularly evaluated. See Appendix 4: Clinical Supervision Evaluation checklist.

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13. Appendices

Appendix 1:

Examples of Supervision Agreements

CLINICAL SUPERVISION AGREEMENT

Date Agreement Made	
Clinician	
Clinical Supervisor	
Line Manager	
Review Date	

1. Clinical Supervision will address the following areas:

_____

_____

_____

_____

2. **Clinical Supervision will take the following form and frequency:**
(e.g. 1:1 meeting, team meeting, peer shadowing etc.)

_____

_____

_____

3. Confidentiality

- The content of the meetings are confidential between the parties to be shared only with the consent of both parties, unless there are issues regarding risk.
- If the clinical supervisor identifies risks to clients or staff (including the supervisee), information may need to be shared.
- If disclosure were considered to be necessary by the supervisor, the supervisee will be informed of the perceived reasons for such disclosure.
- If there were legal requirements, e.g. a coroner's inquiry or a Workcover case, the court may require disclosure by the supervisor who would then have an obligation to comply.
- Supervision content will not be provided to line managers unless previously agreed or others, in relation to performance management of the supervisee, but the supervisee could choose to do so to support her/his case in such an event.

Other areas to consider:

_____

_____

4. Record of Clinical Supervision

Who will record it?

_____

- Supervisors are required to record attendance of supervisees for clinical governance records.
- It is expected that supervisees and supervisors will keep their own records of supervision sessions as needed for their own reference

Where will the records be kept? _____

- Personal paper records will be kept in secure storage by both parties**.**
- If records are to be kept electronically, they must be password protected.

Who has access to this information?

_____

- In most cases, no other parties will have access.
- However, if there were legal issues, e.g. a coroner's inquiry or a Workcover case, the court would have the right to require the documents.
- Clinical supervision records will not be provided to managers in relation to performance management, but might be requested by the staff member to support their case in such an event.

What will happen to the clinical supervision notes when:

- ***The clinician leaves their position?***

  Notes will be maintained/archived in line with local records management policies and General Disposal Schedule. Records will be kept sealed and marked as confidential, with the limitations as above, for at least a 7 year period, after which time they will be destroyed according to the State Records Act of 1997.

  Additional information:

_____

_____

- ***The supervisor leaves their position?***

  The supervisor will endeavour to discuss with the supervisee whether s/he prefers that notes should be archived or passed on to the new supervisor.

  In the event of this conversation not occurring:

  Notes will be maintained/archived in line with local record management policies and General Disposal Schedule. Records will be kept sealed and marked as confidential, with the limitations as above, for at least a 7 year period, after which time they will be destroyed according to the State Records Act of 1997.

  Additional information:

_____

_____

5. Clinical Supervision Meetings

The Clinician will prepare for each meeting by:

_____

_____

The Clinical Supervisor will prepare for each meeting by:

_____

_____

Should a meeting need to be rescheduled we agree to:

_____

_____

6. Other Considerations

- The details of this document can be modified at any time when agreed by both parties.
- A copy of this Agreement will be given to the team leader for their records
- _____
- _____
- _____

Signed: _____ Date: _____

Name: _____ (Supervisee)

Signed: _____ Date: _____

Name: _____ (Clinical Supervisor)

Signed: _____ Date: _____

Name: _____ (Line Manager/Professional Lead)

ALLIED HEALTH CLINICAL SUPERVISION AGREEMENT

Government of South Australia
SA Health

Between Supervisee and Supervisor

Clinical Supervisee Name:	
Clinical Supervisee Level	New Grad: ☐ AHP1 ☐ AHP2 ☐ AHP3 ☐ AHP4 ☐ AHP5 ☐ AHP6 ☐
	Other: ☐ Specify: ……
Clinical Supervisee Profession	
Clinical Supervisee Team	
Clinical Supervisor Name	
Clinical Supervisor Profession	
Clinical Supervisor Classification:	
Agreement Start Date	……../……/…….
Agreement Review Date	……./……/…….
Booking Supervision:	The Supervisee will be responsible for booking supervision sessions with the supervisor
Frequency of supervision:	
Type of supervision:	(e.g.: refer to the framework)
Acceptable cancellation reasons:	(e.g.: annual/sick leave etc.)
Notice of cancellation:	SMS/voicemail/phone call/ e-mail/ other:
Punctuality is expected by both supervisee/supervisor in both starting and finishing on time (unless extenuating circumstances dictate otherwise)	
Emergency consultation is acceptable outside of regular supervision and the acceptable contact arrangements are as follows: phone/e-mail	

Confidentiality

Our understanding is that the content of supervision meetings is kept confidential between the parties. Where there are issues regarding clinical risk and/or performance management, information may need to be shared with other relevant parties.

Should information need to be shared, the supervisor will advise the supervisee in advance of this occurring, including what information will be shared, with whom and for what purpose.

Supervision Goals

_____

_____

Record of Clinical Supervision:

Who will record it?

_____

Where will the records be kept?

_____

Who has access to this information?

_____

What will happen to the clinical supervision notes when:
a) The clinician leaves their position?

_____

_____

_____

b) The supervisor leaves their position?

_____

_____

_____

Clinical Supervision Sessions

The Clinician will prepare for each session by:

_____

_____

_____

The Clinical Supervisor will prepare for each session by:

_____

_____

Should a session need to be rescheduled we agree to:

_____

_____

_____

Should a matter need to be bought to the attention of the line manager, the supervisor and supervisee will:

_____

_____

Other Considerations

The details of this document can be modified at any time when agreed by both parties. A copy of this Agreement will be given to the Line Manager for their records.

_____

_____

Name: _____**(Supervisee)**

Signed: _____**Date:** _____

Name: _____**(Clinical Supervisor)**

Signed: _____**Date:** _____

Name: _____**(Line Manager / Professional Lead)**

Signed: _____**Date:** _____

Appendix 2:
Supervision Log

Government of South Australia
SA Health

ALLIED HEALTH CLINICAL SUPERVISION LOG

Supervisee: **Supervisor:**

Date of Session	Type/length of session	Outcome/actions

Appendix 3:
Notes on Clinical Supervision Session

Government of South Australia
SA Health

Present: _____

Apologies:_____

Date: _____

Topic	Discussion	Agreed action

Agenda items for next session	Preparation required

Signed _____ **Signed** _____

Date _____ **Date**_____

Appendix 4:
Checklist for Supervisors

Government of South Australia
SA Health

CLINICAL SUPERVISION CHECKLIST FOR SUPERVISORS	
Name of AHP:	
Tick when completed	**TASK**
	Supervisor assigned
	Supervisors and supervisee introduced
	Supervision agreement meeting scheduled
Within supervision agreement:	
	Roles and responsibilities discussed
	Goals of supervision decided
	Methods for supervision determined, selected appropriate to skills, experience, and competence of individual and needs and organisation needs
	Frequency and duration of supervision activities determined (appropriated to classification as set out in minimum standards table, AH Clinical Supervision Framework)
	Supervision goals give consideration to educative, supportive and administrative functions
	Specific supervision requirements of professional bodies incorporated into agreement
	Confidentiality and recording of supervision activities discussed and agreed
	Where appropriate, engagement of external supervision support has been negotiated
	Supervision log to be recorded by ..... and saved here .....
	Date set to review supervision agreement and update .....
	Copy of Supervision Agreement sent to Supervisee
	Copy of Supervision Agreement sent to Line Manager (if applicable)

Appendix 5:
Evaluation of Clinical Supervision

Government of South Australia
SA Health

Name of Supervisor: _____

Name of Supervisee: _____

Date: _____

Rating scale
1. Almost never 2. Occasionally 3. Often 4. Almost always

Quality of the Supervision Process	Supervisor	Supervisee
1. We negotiated a mutually acceptable contract specifying format, goals, roles/responsibilities and accountability of both parties.		
2. The supervisor/ee fulfilled his/her commitments as specified in the contract.		
3. The supervisor/ee maintained appropriate professional boundaries in the supervision relationship		
4. The supervisor/ee set and worked to an agenda for the supervision session, in consultation with supervisee/or.		
5. The supervisor/ee was reliable in making time for and punctual in attending the regular supervision sessions.		
6. The supervisor/ee placed a high priority on understanding the client's perspective, and regard for the client strengths.		
7. The supervisor used a range of questioning styles to assist the supervisee to explore and conceptualise issues and solutions		
8. The supervisor/ee worked together to formulate supervision questions and topics to discuss as required		
9. The supervisor/ee kept a reflective journal to assist in the supervision process and the development of reflective practice		
10. The supervisor/ee communicated sensitivity towards cultural and ideological differences relevant to clinical practice.		
11. The supervisor/ee demonstrated clinical skills in sessions (e.g. instructions, role-plays, videotapes etc.).		
12. The supervisor/ee explained concepts and material clearly.		
13. The supervisor/ee respected confidentiality issues, as appropriate.		
14. The supervisor/ee made supervisee/or feel valuable and respected as a colleague.		

Quality of the Supervision Process (continued)	Supervisor	Supervisee
15. The supervisor/ee sought feedback from supervisee/or about satisfaction with supervision.		
16. The supervisor/ee showed enthusiasm, dynamism and energy for clinical practice.		
17. The supervisor created an atmosphere of trust and support.		
18. The supervisor was available for crisis contact.		
19. The supervisor's supervision style was suited to supervisee level of clinical experience, learning style and needs of the supervisee.		
20. The supervisor encouraged presentation of supervisee's point of view and respected supervisee's opinions.		
21. The supervisor helped supervisee to identify their strengths and weaknesses relating to the core skills, knowledge, attitudes and competencies required for professional practice.		
22. The supervisor provided opportunities for practice of clinical skills in sessions, observed performance and provided feedback.		
23. The supervisor was flexible and adapted to changing needs of supervisee in supervision.		
24. The supervisor encouraged supervisee to examine ethical issues relating to practice, in line with professional codes of conduct.		
Outcomes of Supervision	**Supervisor**	**Supervisee**
25. Supervision improved supervisee clinical skills, knowledge, and attitudes relating to clinical practice.		
26. Supervision increased supervisee confidence as a practitioner.		
27. Supervision increased supervisee understanding of the organisation he/she works in.		
28. Supervision increased supervisee knowledge of ethical issues in practice.		
29. Supervision increased supervisee knowledge of relevant local, State and National policies and procedures.		
30. Supervisee feels more enthusiastic about my work as a result of this supervision experience.		
31. Supervision motivated the supervisee to work on developing clinical skills.		

Outcomes of Supervision (continued)	Supervisor	Supervisee
32. Supervisee felt satisfied with the supervision he/she received.		
33. What are the three most positive outcomes that have been achieved from supervision?		
i)		
ii)		
iii)		
34. What three things would you have preferred to have been done differently in supervision?		
i)		
ii)		
iii)		
35. What specific clinical should be the focus of development in future supervision sessions?		
i)		
ii)		
iii)		
36. What additional professional development activities do you think, would be beneficial to support your supervision experiences?		

Appendix 6
Methods of Clinical Supervision and Support

Clinical Support:
Clinical support is a broad, encompassing term that refers to the support provided to clinicians to assist them to develop the quality, safety, productivity and confidence of their work roles. This may include clinical supervision, mentoring, line management support or a range of other mechanisms designed to support the development of AHP skills, abilities and knowledge (Winstanley & White 2003)

Clinical Supervision:
Clinical Supervision is "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety in complex situations" (Marais-Styndom 1999).

Clinical support and supervision may include, but not be limited to, the methods outlined below. It is the responsibility of the supervisor and supervisee to ensure that the methods, frequency and duration of supervision suit the requirements of individuals, health service organisations and professional associations and registration boards.

Supervision Methods

Day-to-Day Supervision
This occurs in real time between the supervisor and supervisee to facilitate the delivery of services to clients in an "informal" "as-needs arise" basis. This is possible when the supervisee has direct access to the supervisor and may occur through discussion face-to-face, over the phone, via email, or by hands-on assistance in delivering services.

Direct Observational supervision
This is direct observation of a supervisee's work by a supervisor during a client interaction for the purpose of giving feedback. This can occur in an office based clinical setting, on a home visit, in a group, co-working with a client, when viewing a video recording of a session or in an office whilst a staff member is on the telephone. This form of supervision gives the supervisor a clear understanding of the supervisee's skills, experience and approach enabling feedback to be very specific. Care needs to be taken to ensure this form of supervision is provided in a positive, respectful and constructive way, keeping with the general principles already outlined for any clinical supervision.

One-to-One Structured Supervision
This occurs as a regular, structured meeting/discussion between the supervisor and supervisee. It may include case discussion, reflective practice, setting and monitoring learning goals, sharing information/knowledge and/or teaching skills. The clinical supervisor is usually more experienced than the supervisee but may be a peer for more experienced staff (AHP4-6) if this suits the supervisee's needs. Feedback is a critical component of supervision to ensure there is a two-way interaction between the supervisor and supervisee.

The frequency and location of these sessions are agreed in the supervision plan and are prioritised and protected by both the supervisor and supervisee. They should occur in an appropriate, confidential environment and may include face-to-face, telephone, videoconference or online discussion.

Group Supervision

This can take many forms and be effective for a range of outcomes and clinical groups. It can provide an opportunity for supervisees to experience mutual support, share common experiences, solve complex tasks, learn new behaviours, and participate in informal training, increase communication, confidence and insight. Group supervision can also enable participants to discuss and learn about cases or approaches that they would otherwise not have been exposed to, hear about a range of perspectives, get feedback from others and feel comfortable to ask questions and express concerns.

The evidence suggests groups should meet weekly for at least 1½ hours with five to eight participants (Li et al 2008) however this may not always be achievable. It may be more appropriate to meet monthly for a longer time frame. Norms, objectives and roles within the group should be set at the outset and outcomes and processes should be evaluated regularly.

Group supervision may be facilitated by a senior clinician or coach or a peer group may elect to rotate the chairperson role. When the group is facilitated by a designated chair, it is their role to ensure the group remains on task, everyone has the opportunity to contribute, the structure is followed and achieves positive outcomes.

Group supervision provides a forum for facilitated open discussion, sharing and learning between a group of clinicians and may include case discussion, topics of interest, inter-professional collaboration and team work activities. It is usually led by a clinical supervisor or facilitator and may occur face-to-face or via phone, online or videoconference.

Peer Supervision

This occurs between two or more experienced AHPs, with a maximum of five (5) participants recommended. It may include consultation, problem solving, reflective practice and clinical decision making. Peer supervision does not require a supervisor to have more experience or knowledge than the supervisee. It refers to a reciprocal learning relationship through the utilisation of skill, experience and knowledge available within the group of peers which fosters and encourages mutual benefits, self-directed learning and the giving and receiving of feedback.

It can provide a forum to share diverse knowledge and experiences and complements more formal methods of supervision.

There are a number of risks associated with peer supervision including maintaining quality and effectiveness of the process, understanding boundaries and limitations of the relationship, lack of leadership causing tension in the relationship and focusing on solutions and advice rather than mutual learning and reflection.

By having established processes, templates and training to follow, peer supervision becomes more effective. Peer supervision may be conducted amongst internal colleagues or with external peers from different organisations. When peer supervision works well, participants meet on a regular basis, set norms and expectations, follow an agreed structure, respect each other as equals and nominate a rotating facilitator for each session.

Peer supervision is recommended as supplementary to the individual clinical support arrangement for SA Health clinicians below AHP3 level.

Other Methods of Clinical Support

Journal Clubs

A journal club consists of a group of individuals who meet regularly to discuss and critically evaluate research articles. Journal clubs are usually established around a subject or clinical area of interest to the members, for

example diabetes management. Journal clubs can take many forms, but generally group members review and discuss an article and then relate its relevance and appropriateness for their clinical practice.

Journal clubs are more likely to have a positive impact on knowledge, skills and behaviour if the following adult learning principles are incorporated into the club:

- Relate the task to personal goals or to the immediate environment
- Present learning objectives as clinical problems
- Use problem solving techniques
- Vary teaching approaches to suit different learning styles
- Use active learner participation
- Provide frequent constructive feedback.

SA Health AHPs, through an on-going Allied and Scientific Health partnership with the International Centre for Allied Health Evidence's (iCAHE), have access to iCAHE's Online Journal Club program which facilitates journal clubs, assists in posing questions, searches the databases and provides a critical appraisal of the research question, providing a vehicle to embed evidence based practice into AHP service delivery.

A Journal Club should be used in addition to clinical support arrangement for SA Health clinicians.

Mentoring

Occurs between two clinicians who have been deliberately matched, with one generally more experienced and skilled who takes the role of the mentor, and the other taking the role of the mentee. Mentoring involves regular dialogue on a range of issues with the agreed upon goal of having the lesser experienced or skilled clinician grow, develop, and address career development, where desired (Marais-Styndom 1999). Mentoring usually focuses on the needs and issues identified by the mentee and is very flexible. Good mentors encourage open conversation, reflective practice and broadening of perspectives and knowledge. A suitable mentor may;

- be profession specific or from a different profession depending on the needs of the clinician
- be a specialist in their chosen field who provides expert advice to the mentee
- have skills in coaching, or facilitating reflective practice but not necessarily have specialised skills

The mentee should choose the type of mentor who will work best for them. For example a physiotherapist new to paediatrics may seek the support of a specialist physiotherapist at a University to learn about best practice initiatives used in metropolitan hospitals. An experienced social worker in domiciliary care may prefer a mentor who prompts them to reflect on their practice and coach them to improve their client centred approach.

Other Related roles or processes.

Line Management:

Line management relates to the accountability for overall performance appraisal and may include some day to day clinical direction or clinical supervision if the manager has a clinical background. The line manager is responsible for the overall performance and outcomes of a team or program and may provide support around service planning, meeting funding and organisational requirements, working within internal and external policies, and allocating rosters or workloads (Victoria Healthcare Association 2008).

Performance Review and Development:

Performance review and development is a tool for reviewing, encouraging, supporting and developing all employees. The performance development process comprises regular reviews within a yearly cycle. Characteristically an employee engages in the performance development process with their line manager, where opportunities for growth, development and support may be identified. Clinical support may be one useful tool identified by the employee and/or line manager within this performance development process. (Western Australia Country Health Service 2008). Where a clinical supervisor and line manager contract exist, performance review and development should include all three. For further information see: SA Health Policy Performance Review and Development, Department for Health and Ageing, www.inside.sahealth.sa.gov.au.

Performance Management:

Performance management is a formal process applied in circumstances where problems with performance exist, such as an employee performing at a substandard level. This process is different from performance development. Performance management is the responsibility of the line manager. This framework is not designed to manage performance issues however regular clinical support may have considerable benefit for clinicians with performance issues. Ideally clinical supervisors and line managers work with the clinician on addressing the issues wherever possible.

Reflective Practice

Reflective Practice is a form of self-appraisal that assists a clinician to create logical order to thoughts and feelings related to working with staff and clients. Reflection is a technique we commonly use with our clients. It may help with problem-solving, with resolving internal conflict or frustration, and in establishing a vision of learning needs (Marrow et al. 1997).

Change History

Any printed version of this document may have been superseded. The current version of this document can be accessed via www.health.sa.gov.au/alliedandscientifichealth

Version	Effective From	Effective To	Change Summary
1.0	Oct 2013		Original draft version
2.0	Nov 2013		Chief Allied & Scientific Health Advisor Edits
2.1	March 2014		Formal release
2.2			

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