

Clinical Governance In Community Health

Clinical Supervision in Community Health: Introduction and Practice Guidelines

1. Introduction

The Community Health Clinical Supervision (CH-CS) is a component of The Victorian Healthcare Association (VHA) Clinical Governance in Community Health Project, which commenced in 2005.

The project was funded by the Victorian Department of Human Services following identification by the VHA community health membership of the need to establish uniform systems of clinical governance in community health. Effective clinical governance requires well functioning systems and processes including those for continuously monitoring and improving the quality of clinical care. Several areas of work, including the development of frameworks and resources to support their implementation have been undertaken. This document outlines the suggested framework for the provision of clinical supervision in community health.

The Eastern Metropolitan Region's Scope of Practice and Credentialing Project (Lime Management Group 2006:23) identified clinical supervision and clinical leadership as key to enabling effective scope of practice and credentialing to occur. Clinical supervision plays a role in ensuring that the quality and safety of services provided to the community is maintained and improved through the development of clinical knowledge and competence in those who are delivering services. Clinical supervision also contributes to overall staff satisfaction and retention (VHA Literature Review 2008:33).

The CH-CS Project recognised that the wide range of professions involved in the delivery of community health services called for the development of a model of clinical supervision which responded to the needs of the community health sector. The project, under the direction of a working group of community health representatives, undertook a comprehensive clinical supervision literature review, reviewed current practice and developed guidelines, resources and tools in consultation with the sector.

This document provides a background and rationale for the development of formal systems and processes for effective clinical supervision in community health services. Minimum and leading practice guidelines are presented as a suggested basis for service improvement in the area of clinical supervision. The paper should therefore be read in conjunction with the following documents.

- Clinical Supervision Policy and Procedure
- Clinical Supervision Contract



- Clinical Supervision Record
- Clinical Supervision Report

2. Definitions

The following terms and definitions are used in this document.

<p>Clinical Supervision</p>	<p>Clinical supervision is a formal process, between two or more professional staff, creating a supportive environment which encourages reflective practice and the improvement of therapeutic skills. The supervisory relationship provides an opportunity to address ethical, professional and best practice standards and to promote appropriate, respectful and effective client care.</p>
<p>Administrative/Management Supervision</p>	<p>Administrative or management supervision is provided by a manager who is responsible for the overall performance of a team or program. Administrative matters relating to service planning, development and delivery are addressed by ensuring that program activities are carried out in a manner that is consistent with funding and legislative requirements, external policy directions and the organisations internal policies and procedures. Staff are accountable to line managers who take a lead role in overall performance appraisal and may provide some clinical direction on a day to day basis if trained to do so.</p>
<p>Forms of Clinical Supervision</p>	<p>The common forms of clinical supervision used in the community health sector include:</p> <ul style="list-style-type: none"> • One to One A single supervisor and supervisee meet together on a regular basis for the purpose of clinical supervision. • Group Group supervision involves the provision of clinical supervision by a clinical supervisor to a group of two or more supervisees. Common issues related to clinical care are discussed by all group members. It may involve teams of people from varying professional backgrounds brought together by similar client groups i.e. early intervention in chronic disease. • Peer Peer supervision is when two or more health professionals meet to supervise another's work. It may involve a mix of case presentations, theoretical discussions, role plays and other case based learning. <p>Peer supervision groups may include one or more individuals who have received group/supervisor training but are not formally acting in the role of clinical</p>

<p>Forms of Clinical Supervision (continued)</p>	<p>supervisor. Group members take turns or elect a group member to convene the group and meet other organisational requirements i.e. line management reporting. On some occasions the group may be joined by a clinical supervisor who is acting in that role.</p> <p>NB: Peer supervision does not meet all the minimum requirements as stated in the guidelines, however it may be considered as a valuable adjunct to other forms of clinical supervision such as one to one, or as an interim measure prior to more formal arrangements being made.</p> <ul style="list-style-type: none"> • Live/Observational A supervisor directly observes a supervisees work for the purpose of giving feedback. Client/supervisee interaction can be observed in an office based clinical setting, on a home visit, in a group or in an office whilst a staff member is on the telephone. <p>As client/s who are the subject of this form of supervision are clearly identifiable, the provision of live/observational clinical supervision is dependent on obtaining written informed consent from the client/s.</p>
<p>Internal Clinical Supervision</p>	<p>Supervision which occurs within or across programs or within each discipline in the same organisation.</p>
<p>External Clinical Supervision</p>	<p>Supervision which involves either a supervisor or supervisee who is external to the agency. It may be arranged and funded by the agency or in situations where a clinician is independently seeking and funding clinical supervision from a supervisor, external to the agency, it should be approved by the agency.</p>
<p>Multi-Agency Clinical Supervision</p>	<p>Clinicians from two or more agencies may receive individual/group supervision from the same clinical supervisor. Alternatively a peer supervision group arrangement may exist between agencies of similar backgrounds and purpose.</p>
<p>Reciprocal Clinical Supervision</p>	<p>A clinician from one agency supervises a staff member from another agency and vice versa (funds may also be transferred between agencies). This reciprocal arrangement could occur between:</p> <ul style="list-style-type: none"> • Community Health & Community Health • Community Health & Acute/Sub-acute • Community Health & other sector

3. The Rationale for Clinical Supervision

3.1 The Anticipated Benefits of Clinical Supervision

A review of current of clinical supervision practice in community health has highlighted the different understandings of the process across disciplines and a range of service contexts.

Despite this there is some consistency in the broad outcomes that community health services may anticipate from developing and implementing a structured program of clinical supervision. These include:

- **Ongoing Education and Professional Development**
The clinical supervision relationship provides an opportunity to meet the specific learning needs of individual clinicians. The process allows for these needs to be met in a manner which is tailored to their level of knowledge, learning style, maturity and professional development.
- **Workplace Support**
Clinicians capacity to deal with job related stress and develop the positive attitudes and feelings required to function effectively in the workplace, can be enhanced through clinical supervision.
- **Workforce Retention**
Retaining a skilled workforce is a high priority in community health services. Clinical supervision can play a key role in improving job satisfaction and contributing to the development and retention of a skilled workforce.
- **Monitoring and Improving Clinical Service Delivery**
Clinical supervision allows for the monitoring, review and evaluation of the supervisees clinical practice. Well administered systems and processes ensure that areas of concern are raised and responded to appropriately. Clinical supervision also allows for practice excellence to be identified and encouraged at an individual level.
- **Continuous Quality Improvement**
Developing and maintaining a culture of learning through reflective practice and other techniques utilised in the provision of clinical supervision can contribute to continuous quality improvement across an organization.
- **Enhancing Lines of Accountability**
Supervisors, supervisees and the organisation have responsibilities in relation to clinical supervision. Ensuring that these are clearly articulated in policy, procedures and supporting documents improves organizational understanding of the lines of responsibility and accountability for clinical practice.
- **Mitigation and Management of Clinical Risk**
Improved clinical supervision and support has been identified as one of a range of strategies that can be employed to reduce the risk of adverse events in health care (Victorian Managed Insurance Authority 2008:12). Clinical supervision programs can therefore play a role in risk management in community health.

3.2 The Evidence Base

An extensive literature review was conducted by the CH-CS project. Methodological difficulties with measuring outcomes, flaws in research design and the lack of agreement on operational definitions of key constructs and models were identified. These challenges will need to be addressed before a broad evidence base can be developed.

The literature review found that while the benefits of clinical supervision are accepted in practice, the literature confirms that sufficient research has not yet been conducted to support the efficacy of clinical supervision in relation to clinical practice and client outcomes. Research has however provided sufficient evidence regarding the positive effects of clinical supervision in relation to staff satisfaction and retention, to ensure that it should be considered in terms of workforce management.

Positive outcomes while difficult to measure have been identified in the following areas (VHA Literature Review 2008:33).

3.2.1 Personal Benefits for Supervisees

Overall the studies that have been conducted show that supervisees perceive clinical supervision as a positive experience and believe that it contributes to their professional growth and development. Areas of improvement reported by supervisees include

- Improved clinical insight and awareness of ability
- Enhanced clinical competence and confidence
- Improved working/team relationships
- Ability to cope with change
- Ability to effectively prioritize workloads

3.2.2 Client Outcomes

There is a general lack of research to demonstrative client outcomes, however one clear exception is provided by Bambling (2003) who found that clients who were treated for depression by a supervised therapist were more likely to have a positive treatment outcome than those who were being treated by a therapist who was not receiving clinical supervision.

3.2.3 Organisational Benefits

A number of organisational benefits have been reported. Key themes include:

- Supervision as a workforce development strategy
As a human resource strategy, supervision provides a multifaceted approach to addressing a range of factors that impact on the ability of workers to function effectively.
- Stress and burnout
Supervision has been found to provide emotional support and protect nurses from stress and burnout in a mental health setting.
- Reduced isolation
Supervisees have reported that regular supervision relieves the negative effects of isolation and improves staff relationships.



- Retention
There have been several studies reported in the literature which confirm the importance of good quality supervision as a key component of effective staff retention.

4. Practice Guidelines

The following guidelines present recommended minimum and leading practice requirements for clinical supervision in community health. They are based on information obtained from consultation with the sector and an extensive literature review conducted in March 2008. They seek to provide a sound basis for community health services that are implementing or wishing to further the development of clinical supervision in their organisation.

All aspects of the guidelines, including documentation, reporting and professional development, relate to internal and external supervision and all forms of clinical supervision including one to one, peer and group.

Peer supervision does not meet all the minimum requirements as stated in the guidelines, i.e. involvement of a trained supervisor, however it may be considered as a valuable adjunct to other forms of clinical supervision such as one to one, or as an interim measure prior to more formal arrangements being made.

Staff may choose to fund their own external clinical supervision in addition to that provided by the agency. These guidelines refer to all clinical supervision approved by the *Community Health Service* irrespective of payment arrangements.

VHA recognizes that the successful implementation of quality and safety systems and processes, including those relating to clinical supervision, requires considerable organisational effort over a sustained period of time. The guidelines provide information which when adapted and integrated into policies, procedures and practices at a local level will assist in the implementation and maintenance of effective clinical supervision.

4.1 Policy and Procedures

As a minimum it is recommended that Community Health Services should:

- Develop a clinical supervision policy which documents an organisational commitment to clinical supervision and clearly articulates that it is valued and understood by all staff.
- Develop a clinical supervision procedure that is clearly defined and includes the roles and responsibilities of staff
- Promote a culture of positive supervision
- Ensure that all staff are aware of their organisations procedures around clinical supervision
- Ensure that clinical supervision is provided to all clinicians, including new graduates, team leaders, sole and isolated practitioners and those new to a program or working in a program that is new to them

- Demonstrate a commitment to review the allocation of time and resources to ensure appropriate clinical supervision is available to clinical staff at all levels (Refer to the Professional Association guidelines at the end of this document)

Leading Practice

- Supervision is provided to all clinical supervisors (including line managers)
- Clinical supervision provides the following three key elements:
Educational – an educative framework for reflective learning

Supportive – encourages practitioners to explore feelings and emotional responses and develop insights related to listening, valuing and caring, and reducing stress

Managerial – promotion of safe practice, reducing risk, maintaining professional and best practice guidelines regarding client care and case management

4.2 Documentation and Reporting

As a minimum it is recommended that Community Health Services should:

- Develop a template for a clinical supervision contract outlining the roles and responsibilities of supervisors, supervisees and the organisation. Contracts should include frequency, length and timing of sessions and processes for dealing with threats to safety, legal or ethical issues and review. (See *Clinical Supervision Contract Template*)
- Ensure that a written contract between the organisation, supervisor and supervisee is agreed upon for each supervisory relationship and highlights the requirements and responsibilities of the three parties
- Ensure that a signed record of clinical supervision sessions is completed and available to the clinical supervisor and supervisee. Agreed actions should be clearly documented.
- Ensure that if duty of care issues arise, the supervisor provides a verbal/written report (as specified by the Organisation) in addition to the quarterly reporting
- Ensure that the responsibility for reporting on peer clinical supervision activities is clearly allocated and monitored in a manner that is consistent with organizational policy and procedures.
- Ensure compliance with organizational reporting requirements to supervisees line managers and other organizational representatives as required. (see *Clinical Supervision Reporting Template*)
- Ensure that supervisors and supervisees have a clear understanding of reporting requirements (verbal or written) between clinical supervisors (internal & external) and line managers

- Keep documentation for a minimum of seven years in a suitable storage location as decided by the organisation.

Leading Practice

- A written record of clinical supervision is maintained that allows the supervisor and supervisee to form the supervision agenda
- Sessions are documented objectively (similar to client file notes) to avoid legal liabilities
- An organisation wide tool is developed to evaluate clinical supervision (Refer to 4.12)
- Regular auditing and/or case note review of client file notes. This contributes to the process of clinical supervision by identifying trends or areas of practice that may need further exploration within supervisory relationships. Case note reviews may be conducted on a stand alone basis or in conjunction with regular client file audits.

4.3 Confidentiality and Privacy

As a minimum it is recommended that Community Health Services should:

- Ensure 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.
 - the line/program manager has duty of care concerns and is required to consult with the clinical supervisor
 - providing relevant information for processes such as the annual performance process, credentialling and scope of practice
 - the clinical supervisor's own supervision, where the supervisee remains anonymous
- Ensure that discussion and documentation of client related issues remains non-identified in the clinical supervision record e.g. client initials only and not the unique record (UR) number
- Inform clients directly or indirectly (e.g. via client rights brochure) that the worker receives supervision and that their de-identified details may be discussed

Leading Practice

As Above

4.4 Professional Development

As a minimum it is recommended that Community Health Services should:

- Provide initial training and continuing professional development for all clinical supervisors in clinical supervision
- Include discussion of clinical supervision, including goals, expectations, responsibilities, contracts and frequency of supervision in supervisee orientation/training
- Ensure that position descriptions reflect the expected level of involvement and responsibilities in clinical supervision
- Ensure that training/orientation for external supervisors includes details of the organisational context, philosophy, values and service mix

Leading Practice

- Clinical supervisors meet key competencies in relation to clinical supervision (see *Clinical Supervision Key Competencies*)
- Organisation wide training is provided to imbed the value of clinical supervision across the agency

4.5 Line Management and Clinical Supervision

As a minimum it is recommended that Community Health Services should:

- Ensure that where administrative/management and clinical supervision is integrated, a clear agenda differentiates each discussion and/or separate meeting times are scheduled to discuss both components of supervision

Leading Practice

- Administrative/management supervision is not provided by the clinical supervisor

4.6 Discipline Specific Supervision

As a minimum it is recommended that Community Health Services should:

- Provided clinical supervision by a supervisor of the same discipline where this adheres to professional practice guidelines (Refer to the Professional Association guidelines at the end of this document)

Leading Practice

As above

4.7 Selection of and access to Clinical Supervisors

As a minimum it is recommended that Community Health Services should:

- Provide access to a clinical supervisor who has relevant professional qualifications, experience in a relevant field, has competency based skills in clinical supervision and is involved in ongoing professional education
- Allow supervisees to nominate their preferred clinical supervisor, subject to endorsement by the agency
- Ensure that there is an organisational process which supports the right of supervisees to raise concerns or complaints about their supervisor or the supervision process

Leading Practice
As above

4.8 External Supervision

As a minimum it is recommended that Community Health Services should:

- Provide access to agency approved clinical supervisors who have relevant professional qualifications, experience in a relevant field, are trained in clinical supervision and are involved in ongoing professional education
- Ensure that clinical supervisors are a member of a relevant Professional Association
- Develop and endorse a written contract between the organisation, supervisor and supervisee which highlights the requirements and responsibilities of the three parties including the requirement for regular (quarterly) written reports from the clinical supervisor to the supervisee's manager (see *Clinical Supervision Contract Template*)
- Ensure that the supervisor understand that in situations where duty of care issues are identified, the supervisor needs to provide a verbal/written report in addition to the quarterly reporting

Leading Practice

- Organisations support approved external clinical supervision in paid time

4.9 Formalization of Clinical Supervision

As a minimum it is recommended that Community Health Services should:

- Formalize current supervision practice (regardless of type) with an appropriate contract and supporting documentation
- Ensure that strategies that support staff such as peer support arrangements, networks, mentoring, debriefing and critical incident management are provided in addition to clinical supervision but are not defined as clinical supervision

Leading Practice

As above

4.10 Forms of Clinical Supervision

As a minimum it is recommended that Community Health Services should:

- Provide access to a range of supervision options including one to one, group or peer supervision or a combination of these when required
- Consider the implementation of peer supervision arrangements as in interim measure prior to more formal arrangements being made.

Leading Practice

- One-one supervision is provided for counselling/mental health practitioners, solely or in conjunction with other forms of supervision.

4.11 Frequency of Clinical Supervision

As a minimum it is recommended that Community Health Services should:

- Provide regular, consistent dedicated time for clinical supervision in an environment with little to no disruptions
- Provide a minimum of monthly clinical supervision sessions is made available to all staff irrespective of the level of experience
- Ensure that the frequency of clinical supervision for overseas trained, part-time and casual staff, sole practitioners, those new to a program and/or those who have additional support requirements is proactively decided

Leading Practice

- New graduates with less than 6 months experience receive weekly clinical supervision
- The frequency of clinical supervision for part-time new graduates is determined in consultation with them, taking into consideration the role and responsibilities of their position and the environment within which it operates.
- Counsellors, psychologists, social workers, drug & alcohol workers, occupational therapists and nurses working in mental health programmes receive fortnightly clinical supervision

4.12 Evaluation of supervision

As a minimum it is recommended that Community Health Services should:

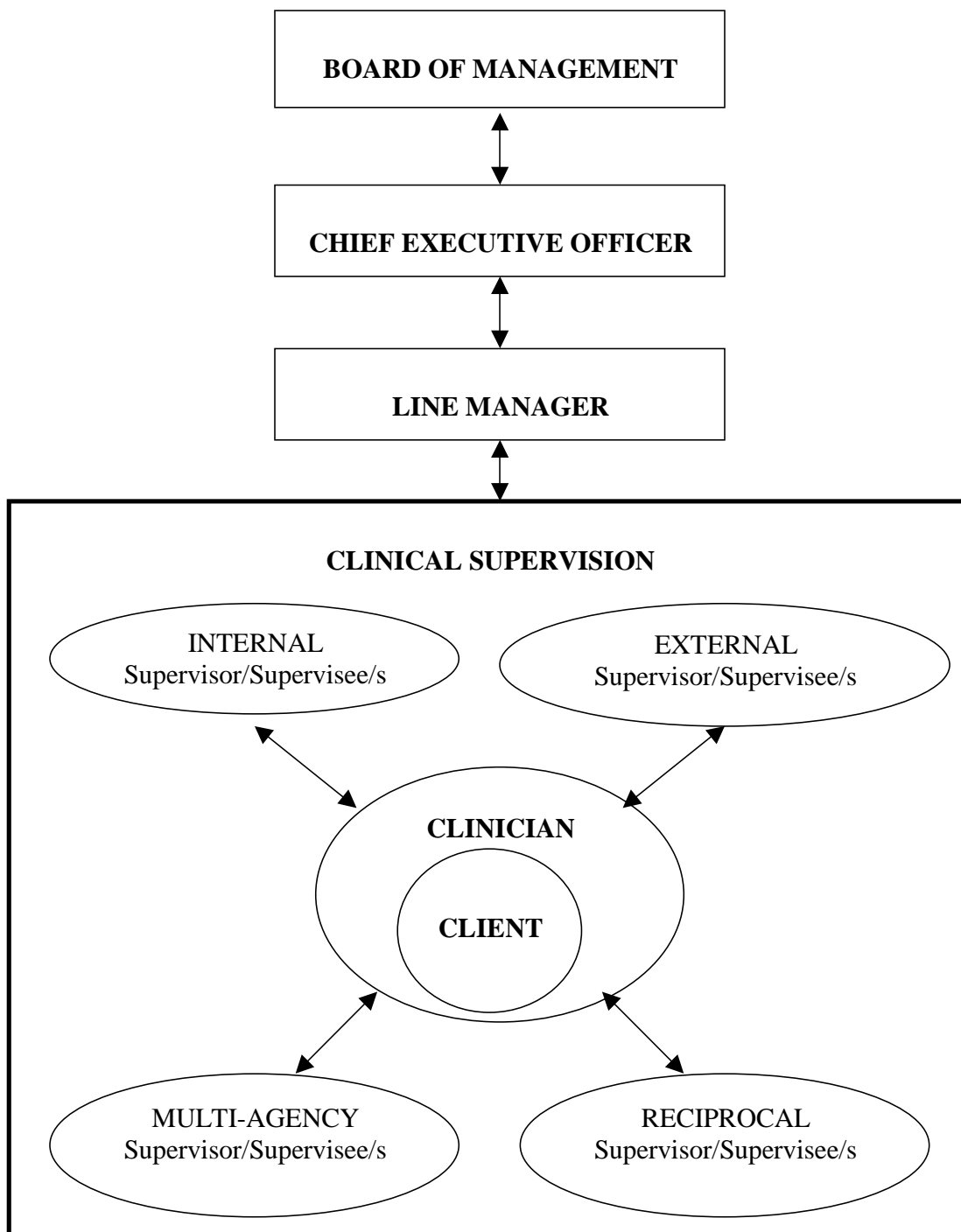
- Ensure that the clinical supervision process is evaluated formally by supervisor and supervisee on a regular basis (annual) or as required
- Establish formal, regular (annual) evaluation of clinical supervision using an organisation wide tool
- Ensure that the evaluation process is established and linked to the objectives of clinical supervision as stated in the Organisations policy and procedures
- Review clinical supervision contracts annually

Leading Practice

As above

5. Framework for Clinical Supervision

This framework has been developed to illustrate the recommended lines of communication outlined in the guidelines above. Reporting from the clinical supervision environment to those responsible for organisational management is a key component of an effective clinical governance system. The framework is an example only and would need to be adapted to the organizational context in which it was being implemented.



6. Funding/Resources

To effectively provide clinical supervision that meets the requirements documented in the guidelines above funding for clinical supervision needs to be allocated.

For Victorian Department of Human Services (DHS) funded programs, clinical supervision, including individual, group and peer, may be counted as a *Direct Care – Indirect Service Time* activity. The *Clarified Counting Rules under the revised Primary Health Funding Approach* acknowledge clinical supervision as time that has been spent away from a client/s in an essential activity to provide support to client/s. (Victorian DHS 2008)

7. Association Guidelines

The Nursing and Allied Health Associations have developed a range of documentation in relation to clinical supervision. These have varied according to each discipline.

The **Nurses Board of Victoria** guidelines (2007:5) identify that the 'level of supervision should be appropriate to the degree of risk of the nursing activity'.

The **Australian Psychological Society** (APS) Guidelines on Supervision (2003) refer to registered psychologists.

The document highlights the importance of

- having a supervision contract
- allocating sufficient time
- providing adequate resources for the supervision process and
- distinguishing between line management and professional development supervision.

The APS policy position on supervision notes that it expects that all psychologists will continue to enhance their professional expertise. The APS acknowledged that dependent on the experience of psychologists, some will require 1-1 supervision, group sessions or more experienced psychologists may utilise supervision on a "need to know" basis.

The National Practice Standards of the **Australian Association of Social Workers** (AASW):Supervision (2000) states there should be a written supervision agreement specifying the qualifications and experience of supervisors. The AASW recommend one hour per week of supervision for recent graduates or for social workers with less than three years experience. For social workers with three or more years experience it is recommended that they receive one hour per fortnight as a minimum.

Speech Pathology Australia (SPA) (2007) supports a minimum of two hours per month of professional and/or clinical practice supervision for all speech pathologists. SPA recommends a minimum of one hour per week of supervision for new graduates, rural/remote positions and sole practitioners.

The **Australian Association of Occupational Therapists** National Policy Paper on Mentoring/Supervision (2000) presents elements of best practice for supervision. OT Australia suggests weekly supervision for the first three months for a new graduate, then ongoing on a fortnightly basis for other practitioners.



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