Implementation of an organisation-wide Professional Clinical Supervision Procedure for the Allied Health workforce

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Introduction

Professional Clinical Supervision (CS) is a structured process to support health workers reflect on their practice to enhance safe, high quality patient care[1]. CS enables teaching and learning at the point of care, enhances professional development and promotes wellbeing[2].

Barwon Health (BH) employs over 450 staff from allied health (AH) therapy professions. Robust clinical governance includes ensuring these staff have access to CS at a level appropriate to their qualifications and experience, have the necessary skills and knowledge to provide effective CS, and comply with national and state mandatory CS requirements, where applicable.

Barwon Health AH staff informally reported inconsistencies in access to, support for, and quality of, CS practice. Differences in the frequency, format and documentation of CS were occurring in the absence of a consistent reporting and monitoring system.

This project, designed in 3 phases, aimed to address the issue by implementing a procedure and monitoring system to ensure effective, evidence-based CS. Only phase 1 results are presented here.

Phase 1: Map current professional clinical supervision practice

Phase 2: Implement a new procedure and monitoring system

Phase 3: Evaluate effectiveness and compliance 12 months later

Method

A validated tool, the Manchester Clinical Supervision Scale (MCSS-26)[3], was chosen to map CS practice. The MCSS-26 tool was distributed electronically to 482 AH staff in October 2018. Data was collected over a 2-week period and included: professional background, experience, employment status, work setting, whether supervision was being received and perceived effectiveness. Data was collected using REDCap and exported to Excel for analysis.

Supervision practices include peer, group & one-on-one models

Results

Response rate was 41% (n = 192). The number of respondents currently engaging in clinical supervision was 69%. Just over half (54%) were 'satisfied' or 'very satisfied' with their current CS arrangement. Staff less likely to be receiving CS were part-time employees (60%), senior grades (see Figure 1), and those working in Mental Health or Aged Care settings (see Figure 2). Evidence of CS completion such as documentation of sessions was infrequent (22%).

Figure 1.

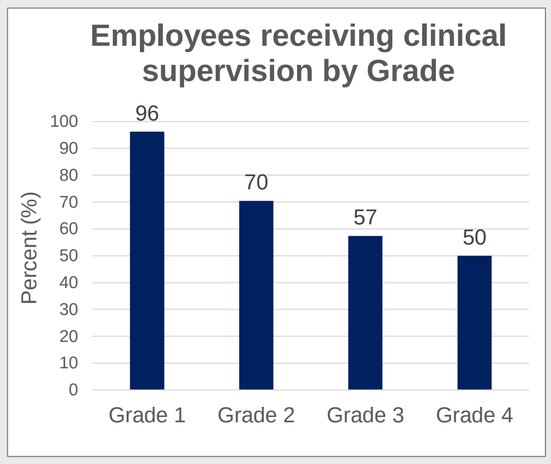
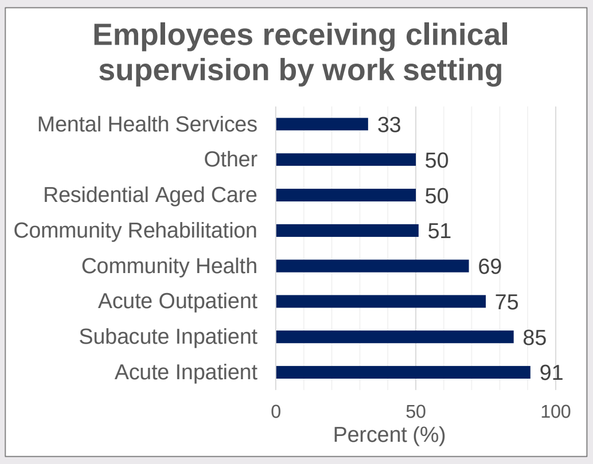
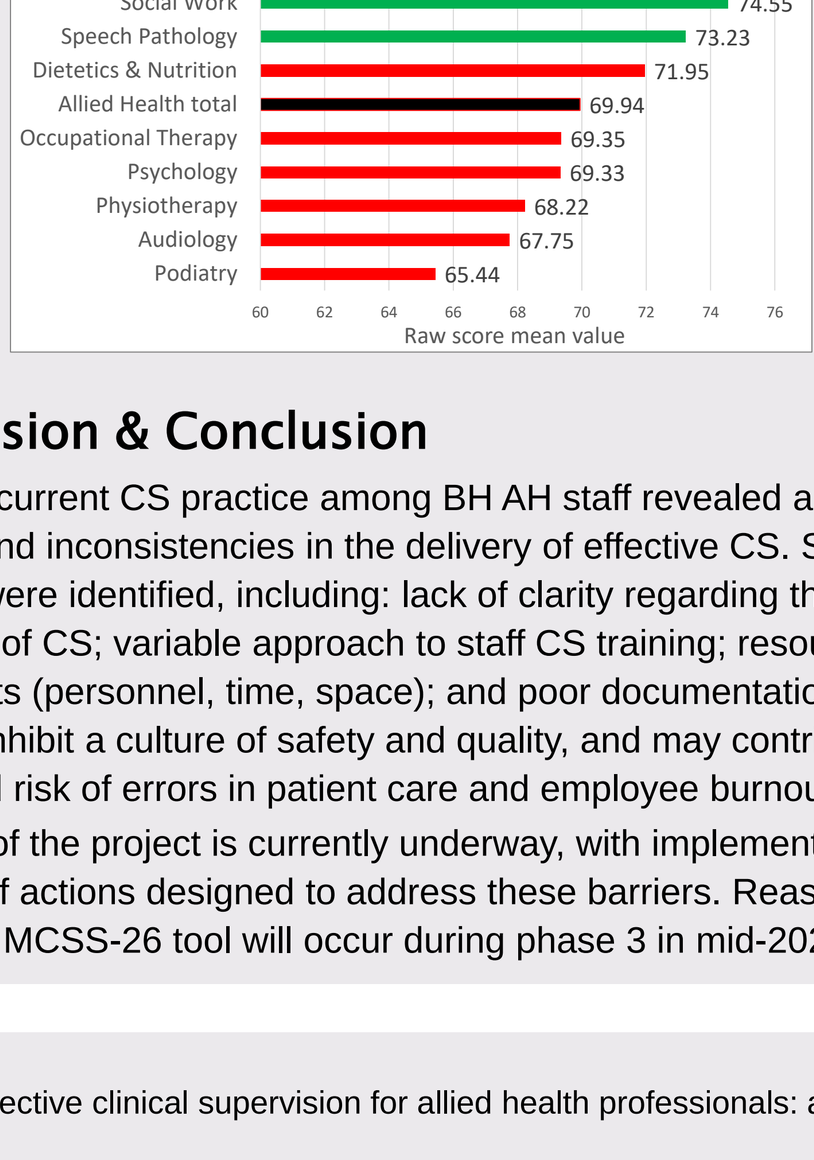


Figure 2.



MCSS-26 results provide a total score indicating CS effectiveness[3], with threshold set at ≥73. The AH total mean score was 69.94, indicating current CS practice is perceived as not effective for the majority of employees (see Figure 3). Only staff from Social Work and Speech Pathology perceived their CS to be effective.

Figure 3.



Discussion & Conclusion

Mapping current CS practice among BH AH staff revealed a number of gaps and inconsistencies in the delivery of effective CS. Several barriers were identified, including: lack of clarity regarding the definition of CS; variable approach to staff CS training; resource constraints (personnel, time, space); and poor documentation. These barriers inhibit a culture of safety and quality, and may contribute to increased risk of errors in patient care and employee burnout.

Phase 2 of the project is currently underway, with implementation of a number of actions designed to address these barriers. Reassessment using the MCSS-26 tool will occur during phase 3 in mid-2020.

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