Building supervision support capacity across the Barwon-South Western Clinical Placement Network Project

Qualitative Evaluation

Report
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creating high performance cultures and leaders

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1 Purpose

This report presents the findings of the qualitative evaluation on the Building supervision support capacity across the Barwon-South Western Clinical Placement Network Project to answer the questions:

1. What difference has the clinical supervision support program (CSSP) made at the individual, organisational and regional levels?
2. What other conditions influenced participants' clinical supervision practice?
3. What is needed to make the CSSP more effective, accessible and sustainable?

2 Background

2.1 Aim

The aim of the Clinical Supervision Support Program of Health Workforce Australia is to expand clinical supervision capacity and competence across the education and training continuum by support measures to train Clinical Supervisors and develop the Clinical Supervisory Workforce[1].

2.2 The project

An evaluation using qualitative methods of the BSW Clinical Placement Network Strategic Project (the Strategic Project) and the current project (Building Clinical Supervision – HWA CSSP Initiative) involving two components - workshop training and workplace learning. These two projects and their timeframes are shown in figure 1. Some participants engaged in more than one type of activity.

[1] HWA Clinical Supervision Support Program - Accessible at http://www.hwa.gov.au/work-programs/clinical-training-reform/clinical-supervision-support-program

Figure 1: Project summary and timeline

<table>
<tr><th>Oct-11</th><th>30/06/2012</th><th>31/10/2012</th><th>Mid Dec 2012</th><th>30/04/2013</th><th>16/10/2013</th></tr>
<tr><td colspan="2"><u>BSW CPN Strategic Project</u>

Establishing a sustainable and effective BSW CPN: Project 3</td><td colspan="4"><u>Clinical Supervision Support Program</u>
Building Supervision Support capacity in the BSW Clinical Placement Network</td></tr>
<tr><td colspan="2">Round 1 (workshop training - novice)</td><td colspan="4">Round 1 (workplace learning)</td></tr>
<tr><td colspan="2"></td><td colspan="2">Round 2 (workshop training - novice and advanced)</td><td>Round 2 (WPL)</td><td>Round 3 (TBD)</td></tr>
</table>

Workshop Training

The workshop training is set out in the following table, which also identifies the various providers of the training. After the strategic project, changes were made to the changes to the subsequent workshops based on feedback in the Strategic Project.

Table 1: Workshop Training and workplace learning elements

	Novice CS training		Advanced CS training
	Strategic project	CSSP	
CSU/DU	Novice 5x half day workshops	2 day workshop	
LearnPRN	2 day workshop	2 day workshop	1 day workshop
TOTR (Teaching on the run)	2 day workshop	-	-
Online (Monash - Advancing Clinical Education – on-line)	-	online	-

Workplace Learning

A clinical supervisor on a one-to-one basis in the workplace delivered workplace learning. Workplace learning was offered to novice workshop attendees who continued to have low self-efficacy on tasks in the Clinical Supervision Self-efficacy tool.

2.3 The evaluation of projects

This evaluation project carried out in 2013 reviewed the outcomes from training provided over an 18-month period. It provides feedback from a selection of current managers and participants on the success and shortcomings of the Clinical Supervision projects and implementation.

3 Evaluation logic

A simple program logic was devised in collaboration with the Program Manager (Dr Schulz) to identify the questions to ask participants and managers who were engaged in the CSSP. Program logic is designed to identify how the intervention or program (activities) contributes to the results (short-term outputs and longer-term outcomes). It also provides an opportunity to identify contextual or environmental issues that may influence the Program's results. While the following Program Logic is not exhaustive, it was useful in distilling the questions that were best answered using qualitative data gathered directly from the participants and managers who were involved in the Program.

Table 2: CSSP evaluation logic

Activities	**Outputs**	**Outcomes**	**Impact**
Distilling clinical supervision as a core competency	Raised awareness of the significance of clinical supervision as a core role responsibility	Improved quality of clinical supervision	Increased clinical supervision capacity
Assessing Self-efficacy	Improved self-awareness of components that makes up clinical supervision. Improved self-awareness of level of confidence and areas needing development	Improved satisfaction of students and staff	Improved pipeline of clinical workforce
Workshop training in clinical supervision	Improved self-efficacy		
Workplace learning in clinical supervision	Improved self-efficacy		
Qualitative questions to evaluate the CSSP			
- What influenced the changes (if any) (i.e. elements of the CSSP)?	- What difference has the CSSP made to CS	What workplace & Regional	What other longer terms impacts could

Activities	Outputs	Outcomes	Impact
- What difference is there between the types of training in terms of effectiveness? - What 'other' strategies/factors/conditions lead to the outcomes?	practice, approach, attitude, Feeling about clinical supervision - What impact did the CSSP have on the workplace? - What other changes occurred (positive and negative)	outcomes can be attributed to the CSSP?	be expected and how would these be measured?
- How can the CSSP be improved and sustained? - What changes could be made to the CSSP to improve its effectiveness, accessibility and sustainability? - What else do you need to move to the next level?			
Situational factors			
What enabled or inhibited CS from taking part on the CSSP?			
What is the succession plan for clinical supervisors?			

(Note: the cell content does not necessarily align across rows)

4 Evaluation method

4.1 Participants - Focus groups, interview and questionnaire

All CS who completed the on-line survey and Clinical Supervision Self-efficacy tool (n=224), their managers [2], and Project Officers (n=2) and clinical supervisors in the workplace learning (n=3) of the CSSP were invited to participate in the qualitative evaluation either by attending a workshop or a one to one interview (sample invitations are attached):

[2] An email was sent to the key contacts on the Steering Committee to forward to the managers of the CS. So it is not known how many managers should have or did receive an invitation.

Table 3: Focus group schedule

Date	Group	**Location**
7 May	Participants	Geelong
7 May	CSSP Project Officers & WPL supervisors	Geelong
8 May	Managers	Geelong
9 May	Participants	Warrnambool
10 May	Managers	Warrnambool

A combination of interview and questionnaires were offered to those who were not able to attend the focus groups. The following chose these options:

Table 4: Participation in focus groups, interviews and survey

	Geelong	Warrnambool
Focus groups	**15**	**4**
Interview - face to face	**2**	**0**
Interview - phone	**3**	**5**
Survey	**2**	**0**
Total	**22**	**9**

4.2 Data collection and analysis

The approach to facilitating the focus groups, gathering and analysing the qualitative data was based on Delbecq and Van de Ven's (1974) Nominal Group Technique (NGT)[3]. For each evaluation question, focus group participants were asked to list their personal views/responses, one per post-it note and then attached these to flip chart paper under each question.

The data were then subjected to a thematic analysis and are presented below under each question.

5 Findings

5.1 Sampling and representation

In more traditional, quantitative approaches to evaluation, response rates are considered an indication of the extent to which the results represent some larger population. However, in qualitative research, such as this evaluation, it is considered more valuable to gather data that provides a comprehensive picture of the subject being evaluated. This was achieved in this evaluation

[3] Van de Ven, A. H. and A. L. Delbecq (1974). "The effectiveness of nominal, delphi and interacting group decision making processes." Academy of Management Journal **17**(4): 605-621.

by inviting representatives from each of the Project groups: those who had attended the training for the Novice, Advanced and WPL, WPL supervisors, managers of participants, and clinical placement coordinators. Further, it is argued that representativeness in qualitative research is achieved when there is saturation of themes or categories that emerge from the data gathered from participants.[4] Before the final workshop and interview the key themes presented under results had been identified multiple times, thereby indicating a level of saturation.

In order to engage as many participants as possible in this evaluation, they were offered a range of options to provide their feedback. In the event, 31 people participated via focus groups, interviews and survey (as per table 4).

It should be noted that 40 of the 224 CSs (18%) who were sent an email invitation did not receive it because they no longer worked in the organisaiotn or their 'in-box was full. More specifically, twenty-eight were no longer in that role, or had left the organisation, and 12 were on extended leave (including parental leave and leave without pay). The Steering Committee verified these responses.

5.2 Demographics

The CSSP participants who attended the evaluation were asked to provide a response to a simple demographic survey. Following is a summary of these responses:

Table 5: Demographic summary of participants

Profession	Number	Graduation year (range)	Highest qualification	Novice training	Advanced training	Workplace learning	Attitude to students
Occupational therapy	2	2001-2008	Post grad	2	2	0	+
Physiotherapy	4	1996-2009	Post-graduate certificate	4	3	0	+
Nursing (1)	8	1973-2006	Masters	3	5	0	+
Education manager (not in health)	1	1995		1	1	0	+
Podiatry	2	1989-2004	Grad dip	1	2	0	+
Speech pathology	1	1992	Bachelor		1	0	+
Social work	1	2011	Bachelor	1	0	0	+
Total	**19** (2)						

Notes:
(1) Not all respondents identified the program they had attended.

[4] Denzin & Lincoln (2005) *The Sage Handbook of Qualitative Research*. Sage UK

(2) This is a higher response rate than the participants involved in the evaluation possibly due to a discrepancy in the attendance list at the focus groups.- people attended more than one activity

It is notable that all participants had a positive view of student supervisions to start with. Some of the comments included:

"Supervising students is important for the learning of students and consolidating knowledge learnt and putting it into practice. It is essential to ensure our future health care professionals are safe and competent practitioners. Also benefits for the supervisor and organisation, ensuring we are implementing best practice, promoting the organisation for future recruitment. Health professionals have a professional responsibility to teach students."

"Challenging, rewarding, keeps me motivated. Responsibility for the future practitioners."

"Provides a learning challenge and need to be prepared yet flexible."

"It is the most satisfying role I have as part of my work in the clinical environment."

"I enjoy supervising students as much as my clinical practise - both the teaching relations and refinement to my clinical skills."

Following are the themes that emerged in response to each question.

5.3 Factors that enabled clinical supervisors to take part in the CSSP

The factors that enabled and encouraged participation in the CSSP were:

- Overt support from management by way of providing time to attend the programs, and obvious interest in the participants' experience of the CSSP. In the eyes of the participants this demonstrated the value and importance granted to the clinical supervision role by the organisation.

- The recognition that supervising students is a role that requires training and preparation.

- Being personally invited to take part in the CSSP, which for some actually raised their own interest in going further with the clinical supervision role. For example, one participants said that "*The offer to advanced training led me to consider taking the role further and strengthened my commitment to it"*

- Flexibility in program delivery – different times and sites of delivery enable participants to fit it within their works schedules.

5.4 Factors that inhibited clinical supervisors from taking part in the CSSP

The factors that inhibited participation in the CSSP were:

- Insufficient planning and notice given to participants to attend the training programs.
- Not having the time to attend.
- The context and rationale for the Program could have been better explained as a means of engaging more staff.
- Part-time work *("Working part time was a restriction in terms of being able to make certain training days and also justifying the time away from my clinical load to be able to take part in the training.")*

5.5 General context factors

Factors identified that could impede the CSSP and clinical supervision in general are:

- Lack of staff time to engage in clinical supervision of students and development of clinical supervision skills.
- Insurance in private practice for clinical supervision.
- Space in private allied health practices.
- Turnover of clinical supervision staff.

5.6 Differences made by the CSSP

5.4.1 Participating clinical supervisors' perspective

Participants generally believed that participating in the CSSP had improved their practice, approach and attitude. Specific changes related to:

Improved understanding of the role and students

- Improved understanding and clarity of what effective clinical supervision is and what it entails.
- Improved understanding of how students learn thereby increasing CS empathy.

Improved confidence and reduced stress

- Improved ability and confidence to provide feedback to students.
- Improved confidence and enjoyment in the role.

Improved structure and skill

- Improved structure in the way they supervise students, and planned for their clinical placement experiences. *("I am able to take more time in*

planning and take steps to ensure I am not stressed by the increase in workload")

- Increase use of alternative strategies and improved time management supervising students.

Improved relationships

- Fostering inter-professional practice and learning
- Changed the way CS relates to students
- Improved communication skills with students
- A realization that student learning is defined by the relationship they have with the clinical supervisor.

"Real learning takes place in the relationship"
"I am generally more positive and see having students as a great opportunity for me, rather than a burden."

4.4.2 Managers' perspective

From the managers' perspective, the CSSP resulted in the following changes in:

Their clinical supervisors:

Improved knowledge, experience resulting in:

- A common language.
- A reduction in avoidance of the tough conversations.
- An increase in ability to resolve issues and make decisions more autonomously.
- Increased willingness to supervise students.
- Increase in the number of students supervised.
- Staff being more accepting of students.
- Better understanding of the psychological health and the student and how to manage this.
- Improved confidence.

Recognition that supervising requires specialist skills and enhanced the legitimacy of the role.

Improved appreciation that they need to identify struggling students earlier

The organisational outcomes
More knowledgeable people in the clinical supervisor roles.
Improved orientation

Enhanced the value and ability of the clinical supervision role, which is expected to:

- Result in more resources devoted to it in the future
- Contribute to a learning culture and their ability to comply with the Best Practice Clinical Learning environment criteria, which will be linked to funding in the future.

- Make staff feel more valued.
- Improve retention and recruitment.

Interdisciplinary/organisational collaboration resulting in:

- Enhanced awareness of other services.
- Working toward the same outcomes.
- Improved consistency.
- Reduced duplication and sharing of resources.
- Improved integration and continuity of patient care resulting.

"Agencies less experienced in clinical placements have benefitted from more experienced staff in other agencies who are part of the partnership."

4.4.3 Little to no change

Additional observations made by individual managers were that:

- There was varying degrees of self-sufficiency probably owing to factors outside of the CSSP.
- The actual model and level of responsibility of clinical supervisors at one organisation had not changed.
- One organisation experienced little impact because the program was not followed by strategies to embed the new skills and respond to workplace turnover.
- Some participants were already interested and had self-selected, self-reliant, so there was no noticeable change in attitude or skills.
- The Program was well suited to allied health and nursing professionals, but did not have the same impact for Aboriginal Health Workers. Even through these participants gained a lot from participating, it did not translate into practice. This may reflect a need to review it in terms of its application to other cultures and settings.

5.7 Aspects of the CSSP workshop training and workplace learning modes that are attributed to the changes

Participants and managers identified the following elements of the CSSP that contributed to the changes.

Workplace learning

- Most participants did not raise any specific observations relating to the workplace learning mode. It was noted that the one on one workplace learning approach enabled the training to be tailored to the individuals needs and the context they worked in, and could fit with their part-time work arrangements better than the workshops.

"I think the key for consolidation and reinforcement of the information, skills and strategies was the 1:1 supervision in my workplace."

Program structure

- There was a generally held view that face-to-face training was more effective than on-line.

- Novice and advanced levels catered for different levels of experience
- As part of the training, some of the key elements identified as particularly valuable were In relation to the story telling, "*partnering, modeling, mentoring, psych supervision; freedom to bring ideas for it*"

Course content, particularly:

- Clarifying the role expectations of the clinical supervisors.
- Providing a formal resource that could be referred to later.
- Recognising students learning needs.
- Decision-making in student management based on assessment, criteria and evidence.
- Mental health resilience model for students.
- Understanding the Australian Nursing and Midwifery Accreditation Council's (ANMAC) competencies and how they relate to practice.

Workshop approach

- Provided a more structured, consistent understanding and development of the clinical supervision role, raising the value of supervising students in the organisational culture.
- The workshops enabled participants from different organisations, departments, levels of expertise and disciplines to share ideas and learn from each other. They provided a safe forum in which to share issues and develop solutions.
- Smaller group work.
- High levels of interaction of participants (i.e. role play in particular) rather than PowerPoint.
- Ability to feedback and reflection on real experiences, and engaging in in-depth exploration of problems that arise in clinical supervision – enables the content to be tailored to the participants needs.
- Brain storming ideas collaboratively.

Tools

- The Planner – self-efficacy assessment (although it "*was a somewhat long and confusing tool*").

Facilitators

- Facilitators were engaging and had a substantial experience of undergraduate students and clinical supervision

5.8 Factors other than the CSSP that influenced changes

Participants and managers identified the following factors other than the CSSP that may have influenced the changes:

Organisational

- Improved clarity of the role expectations
- Lack of consistency regarding who supervises students and how many they can supervise.
- Supportive workplace - Organisational culture.
- Having a supportive network at work and from course participants.

- Part-time work may require co-supervision of students.
- Managers' understanding of mentoring as a result of their own qualifications and experience.
- Prevalence of casual staff who are less willing or able to supervise students.
- Organisational operating deficit so that there is limited resources to support this training.
- Involvement in similar but complementary projects focusing on developing a Supervisors Manual.

Personal characteristics

- Individual commitment to the role.
- Students' attitude.
- Years of experience as a health professional.

Educational provider

- The assessment requirements of the education provider are considered overwhelming, and for some student groups (e.g. nursing) the requirements are vastly different between universities.

"Pressure from the requirements of formal assessment processes from training facility has been stressful at times."

Structural rigidities

"EBA can limit who is prepared to supervised e.g. AH Grade 1"

5.9 Suggestions to improve the CSSP

The following suggestions were made to improve the CSSPs effectiveness, accessibility and sustainability.

5.9.1 Effectiveness

- Open the program to all staff involved in clinical supervision (not just educators).

- Include case studies and scenarios that are more aligned with the situations they are practicing in, particularly with respect to cultural differences (e.g. Aboriginal Health Workers).

- Improve health service – education provider interface:
  - Clarify expectations regarding the role of clinical supervisors and student learning outcomes.
  - Improve communication, integration and coordination between education provider, supervisor and student.

- Survey staff to assess their clinical supervision needs. In a similar vein, one manager suggested that the results of the self-efficacy assessments be shared with the organisations so they can respond to the needs of the clinical supervisors at the organisational level as well.

- Simplify and shorten the self-efficacy tool.

- Improve managers understanding of the Program as part of its promotion by providing more information on:
  - The background on the Program.
  - Why it is needed and the rational and context of the Program.
  - The concepts of clinical supervision, facilitation and preceptoring.

- Establish a clinical supervision development pathway:
  - Clarify the progression and relationship between from novice training through advanced CSSP, certificate 4 and the University Programs.
  - Ensure that the 'train the trainer' module participants also undertake the novice levels so that they understand what they are going to be teaching.
  - Follow workshops with workplace learning.

5.9.2 Accessibility

- One of the most common recommendations to improve it was to provide more notice of up-coming programs, and have these as regular events on the training and development calendar.

- There appears to have been a preference for half-day sessions.

- Consider testing a range of program delivery modes:
  - Video-conferencing was suggested to enable live interaction.
  - Consider having some elements on-line.
  - On-site for more remote health services.
  - Workbooks.

- Continue to fund the training rather than ask participants to pay as this would be a disincentive.

5.9.3 Sustainability

- Sustain opportunities for inter-professional collaboration

- Continue University facilitation

- Create a forum or mechanism for ongoing support of supervisors so they can discuss and solve issues (i.e. online forum)

- Organisational support
  - Managers and staff on the floor demonstrate value for clinical supervision.
  - Continue organisational support.
  - Incorporate into staff performance appraisals.

- Training program:
  - Hold more frequent training sessions to accommodate the high turnover of staff, refresher programs.
  - Regular presentations on the popular/key topics.

- Have an ongoing driver for the CSSP.

5.10 What else is needed to further increase clinical supervision capacity

5.10.1 Strategies to move to the next level of clinical supervision

- Local capacity building
  - Continued participation in the delivery of the training modules.
  - Mentoring/buddying support of the clinical supervisor following the formal training program (one on one or small group).
  - Develop mentoring skills as part of the Program.
  - Identify common competencies across professions and supervise each other.

- Regular planned clinical supervision debriefing and training sessions.

- Organisational support:
  - Management support and encouragement
  - Time and resources.
  - Provide emotional support/pastoral care

- Have students provide feedback on the "three things that worked, and the three things that did not work" for them.

- Articulate measurable outcomes from the Program so that stakeholders understand what's in it for them. For example, make the links with the BPCLE clear.

5.10.2 Succession planning

Very few evaluation participants identified existing succession plans or strategies. One example, however was that all new staff and second year graduates participate in 'in-house' training programs.

The vast majority of participants and managers offered suggestions to facilitate succession planning, and these included the following:

- Establish an Inter-professional Clinical Supervision Network (site specific and Regional) that is coordinated (has a designated coordinator) and has administrative support (i.e. secretariat and structured process). This Network could:

    - Enable clinical supervisors to reflect on their supervisions practices and foster consistency and structure.
    - Regular in-service to refresh and develop skills, and resolve issues together.
    - Share resources and experiences.
    - Supported by an On-Line interactive forum/web-site (consider Share Point) to encourage ongoing communication and sharing of resources and materials and promoting training and other opportunities for development.
    - Provide access to highly skilled/experienced clinical supervisors for advice and mentoring.

- Establish a Clinical Supervision Framework that:
    - Includes agreed and consistent definitions of concepts.
    - Clarifies the path from the Self-efficacy assessment to the advanced modules and workplace learning.
    - Defines roles and levels of supervision.
    - Sets out the continuum of clinical supervision/preceptoring where the primary preceptor is responsible for preparing reports and secondary preceptors provide clinical support.
    - Provides a career structure (for example, in nursing it might be toward the Clinical Nurse Specialist level, or "*preceptor >clinical facilitator>clinical support nurse>nurse educator*").
    - Grades clinical educator coordinator and supervisors for each discipline.
    - Offers progressively more development and responsibility.
    - Provides clinical supervision mentors to support clinical supervisors.
    - Protocols setting out timelines, handover, and so on.

- Organisational support - Incorporate clinical supervision as a core role expectation in the position descriptions of all clinical staff and assess at annual performance appraisals.

- Ongoing development:
    - Provide on-going development and refresher programs, and ensure time is made available to undertake development.
    - Ensure clinical supervision is continually improving by ensuring there is a clear process for receiving feedback on good and poor performance.
    - Provide formal train-the-trainer programs to enable clinical supervisors to train and mentor more clinical supervisors internally.
    - Provide module or session on targeted areas for different staff members (for example, student feedback; the struggling student; Aboriginal Health Workers, and so on).

- Network for current students.

6 Conclusions and key recommendations

6.1 Conclusions

One of the limitations of this evaluation was the low response rate. The reason most often sited for a lack of engagements was that those who were invited did not have the time to attend the evaluations focus groups. Further, all of the participants had positive attitudes toward student supervision, even before their participation in the CSSP. Nevertheless, it is generally accepted that people who feel strongly (either positively or negatively) are most likely to take the time to contribute to such evaluations. In this case, almost all who took part in the focus groups, were interviewed or completed a survey were positive about the CSSP and believed it was of value to them.

6.1.1 The difference the CSSP made

The key differences that the CSSP was believed to have made were related to:

Individual

- Improved understanding of the role, students and their learning needs.
- Improved confidence and reduced stress.
- Improved skill and ability to structure an effective clinical placement experience, and deliver constructive feedback and support struggling students.

Organisational

- Improved student and inter-professional relationships, communication and ability to support students.
- Recognition that supervising requires specialist skills and enhanced the legitimacy of the role.
- Enhanced the value and ability of the clinical supervision role to contribute to organisational outcomes such as retention and recruitment, meeting the criteria of the Best Practice Clinical Learning Environment (BPCLE), which will be linked to funding resource in the future.

Regional

- Interdisciplinary/organisational collaboration resulting in:
  - Enhanced awareness of other services.
  - Working toward the same outcomes.
  - Improved consistency.
  - Reduced duplication and sharing of resources.
  - Improved integration and continuity of patient care resulting.

6.1.2 The issues that might get in the way

The key issues that will undermine the capacity to realize these benefits are:

- Lack of organisational and management support.
- Not having the time to train or prepare for students.
- Prevalence of casual staff.
- Structural rigidities such as the EBA.

- The Program not being adequately explained, promoted or planned with sufficient notice to plan work around.

6.1.3 Suggestions for improvement

The key suggestions to improve the CSSP's:

Effectiveness were:
- Open the Program to all staff.
- Simplify and shorten the self-efficacy tool.
- Establish a clinical supervision development pathway.
- Offer both workshop and workplace learning and mentoring.
- Encourage student feedback and use this to assist in clinical supervisor's continual development.

Accessibility, were:

- Create an annual calendar with more frequent programs and refreshers.
- Test a blend of alternative modes including video conferencing, on-line and on-site workshops.

Sustainability, were:

- Continue funding the Program.
- Create a forum or mechanism for ongoing support of supervisors so they can discuss and solve issues (i.e. online forum).
- Organisational support in the form of management and peer encouragement and support, and providing the time needed to develop and provide effective clinical supervision.
- Have an ongoing driver for the CSSP.

6.1.4 Succession planning

Based on the responses from the people who participated in this evaluation, it would seem that there is very little attention currently given to succession planning for clinical supervision, even thought there was general consensus that the high turnover would warrant this. Strategies to support succession planning included:

- Including clinical supervision as a role expectation for all clinicians, assessing their performance in this area and providing them with support to develop their skills and experience in clinical supervision.

- Establishing a formal Inter-professional Clinical Supervision Network (site specific and Regional).

- Developing a Clinical Supervision Framework that defines the role, its progression and policies and protocols to guide supervision.

- Ongoing development – including continuing the CSSP, refining to meet the needs of non-educators, and staff in non-acute settings.

6.2 Recommendations

Based on the results of this evaluation, the following recommendations are made to improve and sustain the CSSP, and also maintain and expand the gains made by the CSSP:

1. Establish an Inter-professional Clinical Supervision Network to:
    - Enable clinical supervisors to reflect on their supervisions practices and foster consistency and structure.
    - Regular in-service to refresh and develop skills, and resolve issues together.
    - Share resources and experiences.
    - Supported by an On-Line interactive forum/web-site (consider Share Point).
    - Provide access to highly skilled/experienced clinical supervisors for advice and mentoring.

2. Succession planning:
    - Extend CSSP to all staff, not just those responsible for education.
    - Enable more junior staff (including graduates) to take on the role – so that it becomes everyone's business.
    - Build a culture of learning.
    - Organisations to make clinical supervision a core competency and provide resources to support this.
    - Supervising the clinical supervisor - may need a dedicated role for this or a core group of highly skilled and experienced clinical supervisors to provide this mentoring support.
    - Train the trainer program for clinical supervision.

3. Create opportunities for student input, by:
    - Establishing a network for current students.
    - Encourage student feedback and use this to assist in clinical supervisor's continual development.

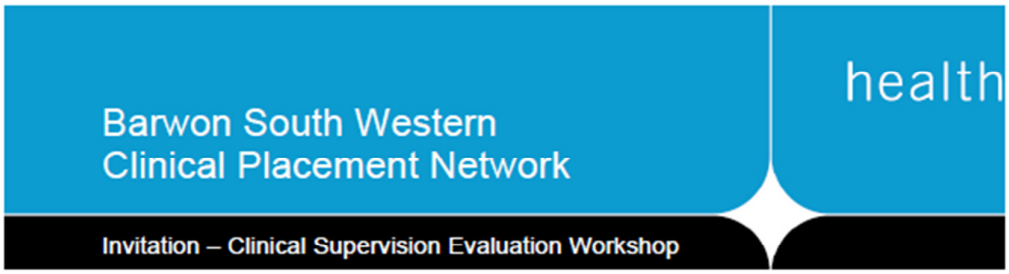
4. Create a Clinical Supervision Framework that defines clinical supervision and articulates the different levels (i.e. primary, secondary supervisors/preceptors), competencies and methods.

5. Establish a Clinical Supervision Framework that:
    - Includes agreed and consistent definitions of clinical supervision concepts.
    - Clarifies the path from the Self-efficacy assessment to the advanced modules and workplace learning.
    - Defines roles and levels of supervision.
    - Sets out different models of clinical supervision, such as the primary supervision model.
    - Provides a career structure (for example, in nursing it might be toward the Clinical Nurse Specialist level, or preceptor to educator)

- Grades clinical educator coordinator and supervisors for each discipline.
- Offers progressively more development and responsibility.
- Provides clinical supervision mentors to support clinical supervisors.
- Includes protocols, policies and other guidelines to guide organisational clinical supervision processes and practice.

6. Continue funding the CSSP and refine it to meet the needs of more clinicians and develop organisational capacity to develop clinical supervisors, by:
    - Testing a blended approach to delivery, including video conferencing, on-line and workbook materials.
    - Offer both workshop and workplace learning and mentoring.
    - Include mentoring development and train-the trainer modules.

7 Attachment – Sample invitations



Invitation – Clinical Supervision Evaluation Workshop

Dear Preceptor / Supervisor / Clinical Educator,

A series of workshop training and workplace learning events have been conducted over the Barwon-South Western region over the past 12 months with funding from the Clinical Supervision Support Program (CSSP) of Health Workforce Australia. You participated in or were eligible to participate in one of the following:

- Clinical Supervision Workshop training at a novice or advanced level;
- Workplace Learning (Supervise the supervisor).

Workshop Purpose:

We are interested in your views of the training and how it could be improved to make it more effective, accessible and sustainable.

Invitation:

You are invited to attend an evaluation workshop to be conducted:

Date: Tuesday 7th May 2013
Venue: McKellar Education and Training Centre, Geelong
Time: 9.30am – 3.00pm (morning tea and lunch provided)

The workshop will be facilitated by Dr Elise Sullivan, DPAR Consulting.

Questions or for assistance to attend:

If you require further information or have any queries concerning this invitation, you can contact the principal researcher:

Dr. Debra Schulz. *Phone: (03) 5279 2492 or Mobile: 0418 180 809*

The Barwon Health Human Research Ethics Committee has approved the ethical aspects of this project. If you have any questions or concerns about your rights as a participant in a research study, please contact: *Bernice Davies, Barwon Health Research & Ethics Office 03 42153372.*

Department of Health

From: DEBRA SCHULZ
Sent: Tuesday, 23 April 2013 4:57 PM
Subject: Clinical Supervision Support Program Evaluation - interview option

Dear Colleagues,
We are able to offer the opportunity for a one to one interview/ discussion by phone as part of the evaluation for the Clinical Supervision Support Program project that has been run across the Barwon South Western region. Dr Elise Sullivan, DPar Consulting will be conducting the interview.

We are interested in your views of the CS Program and how the Program could be improved. Interview times are available as follows:

Date	Time
Tuesday 7th May	12.30 – 1.30pm
Wednesday 8th May	12.30 – 1.30pm
Wednesday 8th May	1.45 – 2.45pm
Thursday 9th May	1.30 – 2.30pm
Thursday 9th May	2.45 – 3.45pm
Thursday 9th May	4.00 – 5.00pm
Friday 10th May	11.15 – 12.15pm
Friday 10th May	12.45 – 1.45pm

Please advise me by COB Wednesday 1st May to book an interview time.
Please don't hesitate to contact me if you have any questions.
Regards
Debbie

Dr Debra Schulz
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