Clinical Supervision in Allied Health: A Process and Model for Policy Development and Implementation

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Certificate of authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the exegesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged. I agree that this exegesis be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Library Services, Charles Sturt University or nominee, for the care, loan and reproduction of exegesis, subject to confidentiality provisions as approved by the University.

I, Sue Fitzpatrick, contributed 90% to methods, 100% to data collection, 95% to text interpretation and 90% to manuscript preparation for the publication entitled “Quality allied health clinical supervision policy in Australia: a literature review.” (Chapter 3).

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I, as a Co-Author for the published papers, endorse that this level of contribution by the candidate indicated above is appropriate.

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ABSTRACT

Clinical supervision has recently gained increased recognition in the healthcare sector as a tool for improved clinical governance and support for health professionals. It is thus important to have a clear understanding about what clinical supervision means, what it entails and how best to approach its implementation. Whilst studies examining clinical supervision are emerging, there continues to be a dearth of studies that provide practical strategies for approaching clinical supervision specifically in allied health.

Numerous studies have identified the need for clinical supervision structure, policy and measures for successful implementation; however, little attention has been paid to the specific needs of the allied-health sector, the role of policy and overall implementation. This study addresses gaps in understanding on clinical supervision in allied health, the need for structure in successful clinical supervision and ways to accomplish this.

The aims of this study were thus to investigate action research as a possible approach to the formation of allied-health clinical-supervision policy; develop a policy of clinical supervision that could be readily accepted and implemented by the people who would use the policy; and provide a foundation on which to base the implementation of clinician-focused supervision and policy development.

This research used a hermeneutic approach underpinned by the work of Hans-Georg Gadamer. Three text sets were generated and interpreted with individual processes: an anonymous survey, action research and meta-synthesis.

The findings from this research included a new and deep understanding of the experiences and needs in allied-health clinical supervision. Action research was found to be a useful tool in clinical-supervision policy development, through participant empowerment and transformation. Action research also structured the progress and development of a unique clinical-supervision policy that met the needs of the allied-health
professionals within the health organisation. A clinical supervision model emerged from the experiences of the allied-health participants. A clinical supervision framework was developed that serves as a foundation for allied-health clinical supervision development and implementation.

This research was important in identifying the clinical supervision needs of allied-health professionals, which is an important first step in achieving successful clinical supervision. The creation of an allied-health clinical supervision model contextualised these needs into a framework for evaluating and implementing clinical supervision for organisations, clinical leaders or individual health professionals. This new understanding, which uses action research to co-create a collaborative clinical-supervision policy based on the needs of the participants, is an important understanding for policy-makers, as it looks further than the policy-creation process to the purpose, aims, function and implementation of the policy. The importance of these findings is the contribution made to identifying current allied-health clinical supervision needs and a practical approach to addressing the difficulties of sustainable clinical supervision programs. The allied-health clinical supervision model is linked with the action research policy development process in a clinical supervision toolkit. This presents the findings as a user-friendly resource for a health organisation, or allied health professional to understand allied health clinical supervision, or to approach the creation or review of their current clinical-supervision situation.

As a result of this study, further research might be conducted on the broader applicability of using action research for health-policy development, particularly in areas where barriers to implementation are anticipated and in other health professions and environs, where the practical clinical-supervision tools can be applied to clinical supervision.
CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction

Clinical supervision among qualified health professionals generally consists of regular reflective conversations between two or more health professionals that aim to support and develop clinical practice (Driscoll 2007). Clinical supervision has an important role in client safety, staff wellbeing and clinical governance, and is thus an important component of providing healthcare (Busari, 2007; Kuipers, Pager, Bell, Hall, & Kendall, 2013; Kumar, Osborne, & Lehmann, 2015; Leggat et al., 2015; Rice, 2007).

This study focuses on clinical supervision in allied-health professions. Key issues in allied-health clinical supervision are finding a shared understanding of clinical supervision in allied health and identifying clinical-supervision needs and practice. There is no agreement on an allied-health implementation framework or clinical-supervision model, although these have been frequently suggested (Ducat & Kumar, 2015; Kumar et al., 2015; Leggat et al., 2015).

This doctoral work is presented in two parts: an exegesis and an accompanying portfolio. This exegesis presents the findings of a research study that explored the requirements for effective clinical supervision in allied health; devised and implemented a clinical supervision policy development process; and developed a model and framework of clinical supervision for allied health. The accompanying portfolio demonstrates my journey as a researcher, and combined with the exegesis, describes how the study contributes to the initiation and implementation of clinical supervision within the Australian public healthcare system. In Chapter 1, I will provide an overview of the study, establish a background for the topic of clinical supervision in allied health and argue for an action-research-based policy development process as a foundation for the implementation of clinical supervision. I will also provide a roadmap of the study and explain the grounding of my work in a hermeneutic methodology.
The study focused on the understanding of clinical-supervision experiences in allied health and the development of a clinical-supervision policy and implementation tools. The research did not include implementation of either the policy or the tools, as the emphasis of the study was on the development process.

1.2 Aims and Scope of the Study

This study aimed to:

1. Develop an understanding of the clinical-supervision experiences of allied-health clinicians.
2. Investigate action research as a possible approach to the formation of clinical-supervision policy in allied health.
3. Develop a policy of clinical supervision that could be readily accepted and implemented by the people who would use the policy.
4. Provide a foundation on which to base clinician-focused supervision implementation and policy development.

1.3 Background and Motivation for the Study

The topic of clinical supervision has gained support and momentum in health professions and health environs over the past 10 years, within the academic literature and in my own participation in conversations and interactions with allied-health colleagues. Support for clinical supervision is evident because health professions in general recognises that it is highly relevant to client safety, clinical practice and staff satisfaction and wellbeing (Dawson, Phillips, & Leggat, 2013; Ducat & Kumar, 2015).

Clinical supervision plays an important role in clinical governance by ensuring client safety (Carroll, 2007; Ducat & Kumar, 2015; Leggat et al., 2015). Clinical governance is important in health organisations as it reflects a commitment to safe and high-quality service provision that is centred on the needs of the consumer (Bishop, 2011). Its function in health organisations is to ensure the quality of health services, consumer
safety and well-regulated practice (Short & McDonald, 2012). It is a system of accountabilities that can facilitate the use of evidence-based practice, reduce clinical risk, reveal poor performance and enhance professional development (Singh, 2003). Clinical governance can be partly achieved by mechanisms such as formal registration, regulation and accreditation of practitioners (Bishop, 2011; Pacey, Harley, Veitch, & Short, 2012). However, many allied health professions are not included in this accreditation process. For example, speech pathology and social work do not have professional-registration requirements in Australia. Moreover, professional regulation does not address individual health professionals’ need for ongoing support, monitoring or practice development (Pacey et al., 2012).

Clinical supervision can facilitate client safety by addressing such gaps in clinical governance through promoting safe and ethical practice; facilitating competent practice and capability through education; providing opportunities for reflection and feedback; and supporting and developing individual health professionals (Milne, 2007). Given the recognised benefits of clinical supervision and its role in health governance and clinician support and development, it is not surprising that there is increasing organisational support for its implementation (Ducat & Kumar, 2015; Gonge & Buus, 2011; Kuipers et al., 2013; Kumar et al., 2015; Leggat et al., 2015; Ross, 2013; Starr, Ciclitira, Marzano, Brunswick, & Costa, 2013).

1.4 Identifying the Gaps for Allied Health

The examined literature describes key issues in allied-health clinical supervision: a paucity of studies pertaining specifically to allied-health professionals, a persistent lack of agreement on what clinical supervision means for allied health, clarity about what is needed in clinical supervision, a need for guidelines or policy to guide this agreement and a lack of knowledge of and agreement on how to implement supervision within the health context.
1.4.1 A paucity of allied-health clinical supervision literature

There has been little allied-health-specific analysis of clinical supervision; what there is has focused on individual disciplines rather than the field as a whole. Published research that has investigated clinical supervision in allied health has included studies of the experiences, understanding and relevance of clinical supervision in dietetics and occupational therapy, speech pathology, social work and physiotherapy (T. Hall & Cox, 2009; Herkt & Hocking, 2010; Martin, Kumar, Lizarondo, & VanErp, 2015; O'Donoghue & Tsui, 2011; Paulin, 2010; Redpath, Gill, Finlay, Brennan, & Hakkennes, 2015; Sweeney, Webley, & Treacher, 2001a). This individual focus, whilst defining clinical supervision for each profession, has not contributed to a shared definition or understanding about the meaning of clinical supervision to allied health professionals as a group. The allied-health sector is unusual in that it appears to be one profession, but in reality functions as a collective of many professions of varying sizes (Boyce, 2001). Understanding the clinical supervision needs of allied health as a group may facilitate a more rapid development of a model that meets their requirements and a stronger voice when requesting organisational support; these are important factors in increasing clinical supervision effectiveness (Ducat, Martin, Kumar, Burge, & Abernathy, 2016).

At the commencement of my study there was little available literature addressing clinical supervision in allied health; however, more recently several papers have emerged examining specific aspects of allied-health clinical supervision, such as what might be appropriately included in allied-health clinical supervision (Leggat et al., 2015). Gaps exist in understanding clinical-supervision experiences and needs within allied health. The published work from my study has contributed to the evolving literature, with several studies citing the papers that constitute Chapters 3 and 6 (K. Bell, Hall, Pager, Kuipers, & Farry, 2014; Ducat & Kumar, 2015; Leggat et al., 2015; Martin et al., 2015; Martin & Tyack., 2013; Nancarrow et al., 2014; Redpath et al., 2015; Saxby, Wilson, & Newcombe, 2015; Seah & McFerran, 2015; Snowdon, Millard, & Taylor, 2015). Studies
examining clinical supervision in allied health as a professional group are emerging. Few, however, identify and discuss specific allied health clinical supervision needs and how successful clinical supervision might be delivered (Kumar et al., 2015; Nancarrow et al., 2014; Pearce, Phillips, Dawson, & Leggat, 2013).

Allied health are viewed as a collective and as such have the power to change practice with the strength of a collective Boyce 2001). Whilst clinical supervision development and implementation varies across individual allied health disciplines, it is not met with the resistance and need for professional culture change that is evident in nursing (Snowden, Millard & Taylor, 2016; Cutcliffe, Fowler, & Hyrkäs, 2011; Lynch & Happell, 2008b). Common clinical supervision issues exist across all health professions, however understanding and targeting issues common to allied health is an achievable first move.

1.4.2 Allied health clinical supervision – what does it mean and what is needed?

There are ongoing attempts to understand what is meant by the term “clinical supervision” in allied health, including an understanding of its function. This struggle to understand clinical supervision in allied health is not simply about defining the term. More recently it has been concerned with what it means for allied health and what it should look like (Dawson, Phillips, & Leggat, 2012; Dawson et al., 2013; Kuipers et al., 2013; Pearce et al., 2013); this is an important step in knowing what is needed in the context of allied health.

Studies examining allied health perceptions of the effectiveness of clinical supervision are one step towards understanding what aspects of it are effective specifically for allied health (Dawson et al., 2012; Dawson et al., 2013; Leggat et al., 2015). These studies, however, are frequently based in practice that is already in place; this narrows their scope to evaluating what is rather than what could be.
In 2015 Ducat and Kumar performed a systematic review on the experience and effects of clinical supervision on allied health working in non-metropolitan healthcare settings. Ducat and Kumar found that whilst allied-health professionals in non-metropolitan settings were more satisfied with clinical supervision, they were less likely to access it. They further argued that there was a need for agreement on the functions of clinical supervision and for clear policies and implementation processes, neither of which had been addressed in Dawson's studies (Dawson et al., 2012; Dawson et al., 2013). Dawson et al., (2012, 2013) examined allied-health professionals' perceptions of effective clinical supervision in a regional healthcare setting. They asked both supervisees and supervisors to identify the elements of clinical supervision that contributed to its effectiveness, such as the availability of time, best-practice protocols and streamlined documentation. Such studies begin to clarify what allied health professionals could expect in the course of clinical supervision, which is important to understanding what it requires and if these requirements are specific to allied health as a group. Whilst a small number of studies have examined this topic, such as Ducat and Kumar (2015) and Dawson et al., (2012; 2013), fewer still use the information prospectively to plan or implement a clinical supervision program.

Basing knowledge about clinical supervision on actual practice is an important part of improving practice, as it incorporates the knowledge of those health professionals who are living the clinical-supervision experience. A small number of studies identify and discuss specific allied-health clinical supervision needs and the ways successful clinical supervision might be delivered. These, however, are in the form of reviews and the interpretation of literature, not based on the practice of clinical supervision (Ducat & Kumar, 2015; Nancarrow et al., 2014; Pearce et al., 2013).
1.4.3 Structure in clinical supervision – an essential element of implementation

Despite the stated benefits of clinical supervision and health organisations’ willingness to participate in it, its implementation is problematic (Brunero & Lamont, 2012; Lynch & Happell, 2008a; Ross, 2013). Several studies evaluating implementation discuss the difficulties in maintaining ongoing clinical supervision (S. Cottrell, 2002; Lynch & Happell, 2008a; Price & Chalker, 2000; Ross, 2013). Key impediments to clinical supervision implementation include poorly defined purpose or content, lack of engagement with health professionals, absence of supporting implementation structures or models and lack of ongoing support and momentum from organisations and clinicians themselves (Bishop, 2008; Brunero & Lamont, 2012; S. Cottrell, 2002; Driscoll, 2007; Ducat & Kumar, 2015; Price & Chalker, 2000; Ross, 2013).

Several recent studies have discussed clinical-supervision implementation across a number of health professions. For example, Brunero and Lamont (2012) evaluated clinical supervision implementation after the introduction of a session-content mode that included training sessions, a handbook and clinical backfill; however, they identified difficulties maintaining groups once the project had finished. Studies examining what it means to implement clinical supervision in allied health are emerging, often focusing on evaluating the effectiveness of programs already in place (Kuipers et al., 2013; Saxby et al., 2015). These studies suggest ways of improving the effectiveness of future clinical supervision; however, it is unclear whether these suggestions could help implement and sustain allied-health clinical supervision.

A consistent message emerges from the clinical-supervision literature: the importance of applying structure to improve the sustainability and implementation of clinical supervision (Ducat & Kumar, 2015; Fone, 2006; Kuipers et al., 2013; Leggat et al., 2015). To date, studies implementing clinical supervision are often in the form of short-term projects within a specific health service (Brunero & Lamont, 2012; Fone, 2006; Lynch &
Happell, 2008c; Townend, 2008). It is thus difficult to plan for or extrapolate the long-term sustainability of clinical supervision when there are no broader plans in place.

Studies where structure has been found helpful include that of Kuipers et al. (2013), who evaluated a multidisciplinary allied health group clinical supervision, and determined that regardless of whether the groups were single-disciplinary or multidisciplinary, the best outcomes were achieved with adequate structure, formal evaluation and management support. The authors also suggest that the development and implementation of organisational policy for clinical supervision are only two of the factors affecting implementation, and that staff and management motivation might also be a factor.

In considering possible structures for clinical supervision, I looked at other states. For example, South Australia has achieved a state-wide allied-health clinical-supervision policy, which has successfully contributed to a shared understanding of the necessity for clinical supervision (Country Health SA, 2009; Kumar et al., 2015). However, it has not counteracted other barriers to implementation, such as time, workload and consistency of approach (Country Health SA, 2009; Kumar et al., 2015). Thus both a clear and shared understanding of clinical supervision and a structure such as a framework or policy are essential to address some or all of the barriers to implementation. Given the calls for policy as a guiding structure and the partial success of policy implementation in other states, I decided to use health-system policy to structure agreement on clinical supervision. Given the role that health policy can play in implementing practice change, I decided that policy was an appropriate tool to facilitate the practical enactment of this agreement. It was clear from Kumar’s study that a state-wide policy had its limitations; I thus proposed that a locally based policy structure might best encapsulate and guide local allied-health clinical supervision.
1.4.4 Involving health professionals in clinical-supervision design and development

Approaches to clinical-supervision implementation have evaluated current clinical supervision, introduced training and or education packages, suggested content or presented a model for implementation (Brunero & Lamont, 2012; Fone, 2006; Gonge & Buus, 2015; Leggat et al., 2015; Lynch & Happell, 2008c). None, however, has been able to successfully resolve the problem of clinical-supervision implementation.

Another major barrier to successful clinical-supervision implementation is the absence of key stakeholders’ involvement at all stages of planning, promotion and implementation (S. Cottrell, 2002). Involving health professionals as key stakeholders not only clarifies expectations but also identifies implementation issues before they become real-life problems (Cottrell 2002). Including health professionals in clinical-supervision policy development is important, as imposing change in a top-down process may increase resistance due to a lack of ownership (Ross, 2013). The emerging literature in allied-health clinical supervision recognises the importance of involving health professionals; however, only a few authors discuss the importance of including health professionals in discussions about their own clinical supervision (D. Cottrell, Kilminster, Jolly, & Grant, 2002; Driscoll, 2007; Lyon, 1998; Ross, 2013). Health professionals in clinical supervision have largely been involved in evaluation rather than in the planning, design and development of clinical-supervision practice.

These studies have shown that involving allied-health professionals in the design and development of their own policy was important to their understanding of their own experiences and the role these could play in planning for a future ideal of clinical supervision. The choice of research methodology supported collaboration with the allied-health professionals in developing both a theoretical and practical understanding of the relevant needs and experiences.

In this section I have presented several barriers to clinical supervision in allied health: a lack of knowledge and agreement on what clinical
supervision means to allied health, a lack of health professionals' involvement in clinical-supervision design and development, an absence of an agreed structure and a gap in understanding how best to sustain clinical supervision through implementation. I have described my decision to use policy as a structure for clinical supervision and to involve allied-health professionals in the design and development of that structure. In the next section, I will describe the situation at the time my research began, to clarify my reasoning for choosing policy as a clinical-supervision structure.

1.5 The Situation When the Research Began

1.5.1 An Australian public healthcare organisation

This study was completed within a public health context in the state of New South Wales, Australia. Health is “a state of complete physical, social and mental well-being” (World Health Organization, 1946, p. 425). A health system is “all activities whose primary purpose is to promote, restore and/or maintain health” (World Health Organization, 2011, p. 9). Australia’s healthcare system contains a mix of public and private health providers and settings (Australian Institute of Health and Welfare, 2014). Public health services in Australia are funded through state and territory funds and Australian national government funds. Private services are funded through non-government organisations such as businesses or charities.

Governance within New South Wales is the domain of New South Wales Health, which communicates necessary and mandatory edicts through state-wide policies (New South Wales Health, 2016). New South Wales Health organisations are required to comply with all New South Wales Health policies. Individual health organisations can develop local policies to clarify a New South Wales Health policy, process or standard, or in the absence of specific guidance from New South Wales Health (New South Wales Health, 2012). New South Wales Health had no clinical-supervision
policy at the time of commencing this study, nor did the participating health organisation.

1.5.2 Allied health – a professional collective

Allied-health staff are the focus of this study. Allied health is a composite of health disciplines that are commonly defined as neither nursing nor medical professionals (Boyce, 2001; Everson, 1999; Thomas, McLean, & Debnam, 2011; Turnbull, 2009). In Australia, the term has many meanings, including which professions depending on the country, state, and health organisation. This makes defining allied health a challenging but dynamic process, which is best done with health professionals who have contemporaneous insight into the group being discussed. For the purpose of this study, allied health has been defined as those professions bonded through being separated from medicine and nursing (Boyce, 2001; Everson, 1999; Turnbull, 2009). Allied-health professionals work in a wide range of health environments including hospitals, schools, clinics, home health, long-term care facilities, rehabilitation and palliative-care centres (Duckett, 2007; Thomas et al., 2011). Allied-health professionals are often supported by organisational structures that cross both professional and organisational boundaries (Braithwaite & Westbrook, 2005; Mueller & Neads, 2005; Nancarrow, Roots, Grace, Moran, & Vanniekerk-Lyons, 2013). Within the health organisation there was a readiness within allied health that was not evident within the nursing professions, which supported an allied health approach to clinical supervision.

1.6 The Right Time for Policy

The motivation for policy development and the support received from the health organisation was in some respects due to timing, both political and professional, as explained in this section.

1.6.1 My own experience in policy development

As the researcher, I had experience in supervision-policy that galvanised me to want to collaboratively develop a clinical-supervision policy. This
was at a time when the organisational leaders in my health organisation were attempting to develop a general allied-health clinical-supervision policy, with a recognition that this was needed from a clinical-governance and safety perspective. There had recently been a formal inquiry into the state of the New South Wales acute healthcare system following the death of a teenage girl whilst in hospital (Garling, 2008). The resulting report from the inquiry identified clinical supervision as an area requiring significant improvement (Garling, 2008). I had already completed a substantial amount of reading on the topic of clinical supervision, because it was a large part of my role as a head of discipline, and a growing area of personal interest for me. This would have placed me logically in a position to comment on the supervision policy that was being proposed by a small number of allied-health leaders. A policy draft was put forward for comment from the allied health heads of discipline. I found it difficult to engage with the document. This was a topic I was passionate about, and I had to question myself about why it was such a chore to review the policy attempt. Was it because I had not been involved? Was it because I had specific ideas about the way a policy should look like?

I was surprised by my absence of concern for what the policy contained. The policy looked adequate overall, and was written by appropriately senior staff. Yet I experienced very little impetus to comment. I forced myself to make a few cursory comments and passed it on as meeting with my approval. That was an eye-opening moment for me. If a person who was well-read on the topic, and who had experience and interest in clinical supervision, could not be moved to make more than superficial comments, what were the chances that a less-interested health professional would? I wondered what it was about that policy that only evoked apathy. As I reflected, I realised that even if the document addressed my supervision needs, I was unable to see what these specific needs were. In addition, I found the wording to be very formal and the content too broad. Also, as I had been requested to comment on an already-formed policy document, I found it very difficult to see what was missing, or to visualise what I wanted to see in the document. In my view, it felt like being handed an
almost finished painting and asked if there is anything missing or if I would like to change anything. I only felt able to apply touch-up paint, as the picture was already fully formed.

1.6.2 Local motivation for policy

At a state level the approach to clinical supervision was one of broad guidance and support (Health Education and Training Institute, 2012). New South Wales Health did not have a clinical-supervision policy. At a local level, the recommendations resulting from the Garling Inquiry (2008) were the catalyst for the leadership of the health organisation to support my development of an allied-health clinical-supervision policy.

Kingdon (1984, p. 94) proposed a framework explaining why some policies are successful, whilst others are not. He explains this as a “policy window” where the political agenda and a policy solution come together. In the case of my study and the proposed development of clinical-supervision policy, the Garling (2008) inquiry was a political impetus. The requirement for policy and the drive to achieve it are often precipitated by a major practice, or “focusing event” (Kingdon, 1984, p. 99) that can seed significant changes within the health system. Such focusing events are few; however, they are often experienced as crises for health systems and thus act as catalysts for major reform. Several such events, such as the Garling inquiry (2008), have occurred in Australia.

Garling’s recommendations for the implementation of clinical supervision across health professions included defining the meaning of clinical supervision and what it included, and the development and implementation of a state-wide clinical-supervision policy (Garling 2008). The implementation of these recommendations was strongly supported by New South Wales Health, and thus provided further impetus for the local health organisation to support the development of a clinical-supervision policy. Several authors have acknowledged the importance of organisational support in successfully implementing clinical supervision in any clinical setting (Buus, Cassedy, & Gonge, 2013; Kuipers et al., 2013;
Lynch & Happell, 2008c; Ross, 2013). Given the absence of a New South Wales Health clinical-supervision policy, it was appropriate to consider a locally developed approach.

1.7 The Right Approach for the Policy

A need for clarity and shared understanding and an implementation structure have been identified as gaps in clinical supervision in allied health (Dawson, Phillips, & Leggat, 2012; Dawson et al., 2013; Kuipers et al., 2013; Pearce et al., 2013). I identified policy as a familiar and accepted structure in health organisations that could facilitate shared understanding and implementation. In recognition of this, as previously described, a clinical-supervision policy was attempted through my health organisation. The attempt was unsuccessful, as there had been little thought to whether this met the needs of the health professionals, what those needs were and how this might affect the quality and effectiveness of clinical supervision. As a result of my own knowledge and experience, it was clear to me that policy was key to structuring a shared understanding and definition of clinical supervision needs in allied health. This insight into the difficulties in implementation led me to believe that an alternative policy-development process was required. In this study the clinical-supervision policy functioned as the structure through which clinical supervision was enacted.

1.7.1 Policy – giving clinical supervision a necessary structure

Health-system policy is a process of establishing a shared and consistent approach to health activities, or to a problem and its solution (E. Bell, 2010; Colebatch, 2002). In New South Wales, New South Wales Health sets the health-system policy agenda through the development and distribution of policies and guidelines. New South Wales Health sets clear expectations that compliance with health system policy is mandatory and compliance with guidelines is recommended (New South Wales Health, 2016). Health-system policy has a greater potential impact than broad guidelines because policy enables enforcement of an agreed
understanding (Collins & Patel, 2009; Kumar et al., 2015). Health-system policy can result in sanctions for non-compliance, such as disciplinary actions, compared with guidelines that can only clarify expected practice (Collins & Patel, 2009). Health-system policy demands accountability from both health professionals and organisations. Given that policy is a familiar structure in health organisations to communicate the need for structure in clinical supervision, I chose it for this study.

### 1.7.2 An alternative policy-development process

Health-system policy development does not have a standardised approach (Colebatch 2002, Buse, May, Walt 2005). There is considerable variation among authors about when, where, if and with whom to consult in the process of developing policy (Bridgman & Davis, 2000; Buse, Mays, & Walt, 2005). The approach taken depends on the governing body or organisation (Bridgman & Davis, 2000; Buse et al., 2005; Pan Canadian Joint Consortium for School Health, 2010). Disagreement about the best way to proceed in policy development makes it an imprecise process, and it is difficult to determine what techniques should be used, when and by whom.

Two contrasting approaches to policy development that can be applied to health system policy are top-down and bottom-up (Buse et al., 2005; Colebatch, 2002; Hoeijmakers, De Leeuw, Kenis, & De Vries, 2007). A top-down policy-creation approach to create clinical-supervision policy would be developed by a small number of people in the organisation who have the designated authority, power or clinical-supervision expertise within the organisation (Buse et al., 2005; Hoeijmakers et al., 2007). The policy would subsequently be communicated to, and implemented by, those in frontline services (Buse et al., 2005; Hoeijmakers et al., 2007). This was the approach used in my health organisation in its first attempt at a clinical-supervision policy. The top-down approach is useful in situations where the policy is directed from a central point, and is able to clearly solve the problem or issue (Buse, 2013). A disadvantage of top-down policy development is the distance between the policy developers and
implementers, which could lead to unexpected barriers such as a lack of significant shifts in thinking or actions by the people who are required to implement the policy (Buse, 2013; Colebatch, 2002; Hoeijmakers et al., 2007).

Conversely, bottom-up policy-making is interactive; several stakeholders, including those responsible for policy implementation, develop the policy (Buse et al., 2005; Colebatch, 2002; Hoeijmakers et al., 2007). A bottom-up policy-development process is one way of establishing clinical supervision with a clear and shared understanding and consistent approach to clinical supervision (Colebatch, 2002; S. Cottrell, 2002; Kumar et al., 2015; Lynch & Happell, 2008a). A bottom-up approach to policy development acknowledges the policy implementers’ active role in developing the policy (Buse et al., 2005). Advantages to the bottom-up approach include participation, ownership, identification of barriers to policy implementation, and decreased resistance from health professionals (Elsey & Lathlean, 2006; Pan Canadian Joint Consortium for School Health, 2010). There can also be disadvantages, including unexpected changes to the policy as a result of wide consultation, and difficulties in meeting formal policy objectives, which may become diluted by such wide consultation (Buse et al., 2005).

Policy-development initiatives for clinical supervision are not always embedded in the culture of health organisations; this can affect successful implementation of clinical supervision (Lynch & Happell, 2008b). As discussed earlier in this chapter, engagement is key to clinical-supervision implementation. It was therefore important to ensure that all stakeholders were invited to participate and contribute to clinical supervision throughout the process (S. Cottrell, 2002; Lynch & Happell, 2008c; Ross, 2013).

1.7.3 Policy implementation

Policy provides structure for the pursuit of specific objectives, however implementation of policy is more than the execution of these, by achieving collective action accordant with participant views (Colebatch 2002).
Colebatch uses a model to illustrate the vertical and horizontal aspects of policy implementation. The vertical dimensions of implementation move from those who direct policy in the organisation, whose interest lay in compliance. The horizontal dimensions applies to the process of achieving the outcome and in those who facilitate this. It was clear in my study that there was a need to bring the horizontal and vertical dimensions closer, to empower health professionals to be both collective policy makers and implementers.

The policy development to implementation journey is traditionally placed into a stages heuristic, moving from policy development and consultation to policy implementation and a focus on policy outcomes (Jenkins-Smith & Sabatier, 1994). Stages models do not address the factors that influence progress throughout the stages. Colebatch (2002) acknowledges these factors by describing the vertical and horizontal dimensions of policy implementation.

There are however, several theoretical frameworks which examine trust as key factor in policy implementation. The Advocacy Coalition Framework proposes that a person’s core policy beliefs affect their ability to accept information based on whether it is consistent or inconsistent with their beliefs (Jenkins-Smith & Sabatier 1994). The need for health professionals to have a clinical supervision policy consistent with their beliefs and needs was an important to the policy’s acceptance. The Transaction Cost Framework (Levi 2000) proposed that both trust and distrust are important to implementation of policy and that high levels of trust requires fewer resources to monitor and enforce policy (Levi, 2000, Lubell, 2007). This has implications for the role of the organisation in engendering trust in policy development and implementation processes and for my choice of a clinical-supervision policy development process that facilitated this trust.

1.7.4 Action research as a proposed policy-development process

I chose to use policy to provide a structure for clinical supervision in allied health; however, given the absence of guidance on how to develop
clinical-supervision policy, I looked at my own experience in clinical supervision and saw the need to do things differently. I wanted to address the issue of needing structure and engage allied-health staff in the design and development of their own clinical supervision.

Action research was able to provide the high levels of engagement, participation and collaboration that I required to make the policy relevant to the allied-health participants (Freshwater, 2005). Through using collaboration to develop the clinical-supervision policy, I aimed to produce a shared definition, obtain organisational support and provide a structure that was endorsed by those who would eventually implement the policy. I anticipated that the clinicians’ engagement would reduce the implementation difficulties observed in several nursing studies, such as negativity, suspicion and lack of engagement (Cutcliffe, Fowler, & Hyrkäs, 2011; Lynch & Happell, 2008b).

Collaboration and participation are essential to engage health professionals, who are key to the success of the policy-development process (Deery, 2005; Elsey & Lathlean, 2006; Morrison & Lilford, 2001). Engagement with health professionals has been identified as important for policy development and for identifying clinical-supervision needs (Driscoll, 2007; Price & Chalker, 2000). For these reasons I made a decision to use action research. Action research enabled me to collaborate with the clinicians who were engaging in clinical supervision and address many of the identified barriers to implementation to establish a clear and shared understanding of clinical supervision in allied health.

Action research has seen only limited use as a policy-development process. Frequently it has a public-policy or health-service development focus, rather than a focus on health-system policy that sees health professional as the policy consumers (Dold & Chapman, 2012; Elsey & Lathlean, 2006; Fletcher et al., 2011; Israel et al., 2010; Matthews, Jackson Pulver, & Ring, 2008). Studies using action research in either policy development or exploration of clinical supervision suggest that the process of participation in action research is as important as the outcome,
due to the effects of collaboration and inclusion on participants (Deery, 2005; Fletcher et al., 2011).

Action research was thus used to facilitate a bottom-up policy-development process in this study; the process was supported by the health organisation’s leadership as well as its senior clinical staff. Few constraints were placed upon the policy-development process, as clinical supervision was not regulated by policy within the health service and the objective to develop a policy that would be readily accepted across allied health.

My study addressed the issues of a need for shared understanding about the purpose and definition of clinical supervision in allied health, identified allied-health-specific supervision needs and addressed the need for a structure and clinical-supervision implementation models through the development of practical tools.

1.8 Overview of the Exegesis

Research aimed at changing practice in the workplace requires a practical approach (Costley, Elliott, & Gibbs, 2010). However, a theoretical overview must be included to ensure higher-order reasoning and evaluation of the issue (Smits, 1997). Thus it was essential to choose a research approach that could accommodate both the practical and theoretical requirements of this study. This exegesis is an expression of my journey to do so.

The exegesis is structured to demonstrate both the journey of the research and my own journey as the researcher. The purpose of a professional doctorate is to present research demonstrating how a researcher’s investigation has led to or will lead to advances in knowledge and/or changes in work practices (Wheat, 2007). An exegesis is a written body of work that integrates and situates the research or investigation within the profession, highlighting how the study can be integrated into practice. This exegesis demonstrates the outcomes of my study and the implications for allied-health clinical supervision practice.
In Chapter 1: Introduction, I have outlined the aims and motivation for the research. In describing the motivations, I have highlighted gaps within the allied-health clinical supervision landscape. I have described current allied-health clinical supervision and what is needed to make it more effective. I have also presented the current state of allied-health clinical supervision at the state-wide and organisational levels and my personal situation at the commencement of this study. I have explained why and how I chose to address these identified gaps through a policy-development process. The chapter finishes here with a map of the exegesis and attached portfolio.

In Chapter 2: Method, I will outline the chosen hermeneutic methodology used in this study, which is within an overarching interpretive theoretical framework. I have chosen to present the method as the second chapter because in hermeneutic research, texts are considered essential research material and are a crucial component of hermeneutic research (Crotty, 1998). Thus the documentation of the review of available literature was created as a research text. The literature review serves as both a product of the research and a summary of the literature. The structure of the research is described as having three text sets and five text-generation processes. I will describe the research participants, the text generation and my interpretive processes. Finally I will outline the steps I took to ensure the quality of the research, and describe the difficulties I encountered in the field and the limitations of the methodology and research process.

Chapter 3: Literature Text Set, is the first of three chapters that uses published or submitted peer-reviewed journal articles as the main body of the chapter, functioning both as a traditional literature review and as a text. I chose to include these publications as part of this exegesis because they are individual research texts, and the process in which I engaged to produce them was integral to the hermeneutic research process. The publications function within the hermeneutic study as generated texts, and provide evidence of my changing understanding of allied health clinical
supervision across the study. The papers as exegesis chapters have introductions and summaries as well as any relevant information aimed at assisting the reader to contextualise the chapter as a whole and the information within it.

The publications also demonstrate the relevance of the research to the broader health-professional community, a requirement of a professional doctorate (Wheat, 2007). I chose to publish Chapters 3, 4 and 6 as papers because they focused on topics that were highly relevant to contemporary allied-health clinical supervision practice. Given the identified gaps in this subject, I felt that it was important to publish the findings in a timely manner.

Chapter 3 sets the scene for the research study by presenting the available literature: first within a published literature review and second through an update on literature developments since its original publication and throughout the exegesis. The literature review outlines some of the studies on clinical supervision in health professions and the key emerging messages. These messages concern the need to be in agreement on an understanding of clinical supervision as well as the need for overarching guidelines or policies to facilitate this understanding. The literature review was published in 2012 and is a representation of my pre-understanding at that point in the study; it includes literature up to the date of submission for that publication. Pre-understanding is a term used in hermeneutic research to describe the knowledge and orientation that the interpreter brings to the research and includes their biases and prejudices (Allan & Dixon, 2009; Paterson & Higgs, 2005; Sharkey, 2001). More-recent literature is summarised at the end of this chapter and discussed across the exegesis, as evidence of ongoing examination of emerging literature and my changing horizons. I summarise the available research to give a background to the study and to clarify the importance of the research. The aim of this chapter is to contextualise the research in relation to previous research and identified gaps within the literature.
Chapter 4: Co-creation of an allied health clinical supervision policy: a participative approach presents a prepared and submitted manuscript titled “Co-creation of an Allied Health Clinical Supervision policy: A participative approach”, which focuses on participants’ journey through an action-research process. I frame this chapter with an introduction and chapter summary, first, to contextualise the chapter findings within the exegesis and second, to situate my changing horizons at this point of interpretation in the study. The process for developing a clinical-supervision policy for allied health is described in detail. My interpretation of the action-research policy-development process examines the usefulness of the action-research process in policy development and the overall benefits to the organisation and the participants.

Chapter 5: A clinical supervision policy for allied health, presents the formal clinical-supervision policy text that was the output from the action-research groups. This chapter presents the content and structure of the policy in a sequence that mirrors the policy-development process. First, the policy is presented in the text that frames it, and in its context within the health organisation; second, the chapter describes the 12 key principles guiding the body of the policy. In this chapter I detail the reasoning behind the participants’ decisions about policy content and the role played by the action-research process.

Chapter 6: Meta-synthesis of texts formed a foundation for practice is presented as a peer-reviewed publication titled “Clinical Supervision in Allied Health: A model of allied health clinical supervision based on practitioner experience”. This paper describes a new clinical-supervision model: the Allied Health Key Dimensions. The chapter describes four broad domains defining the needs of clinical supervision in allied health and the role these four domains play within the model. These four domains emerged from the participants’ experiences. The model is discussed as a tool for supervision implementation. The progressive nature of the text-generation process resulted in the building of texts and understanding for interpretation using the hermeneutic method. This
chapter is presented in two sections representing the two approaches to a meta-synthesis in the study. The two outcomes from the meta-synthesis are an allied-health clinical supervision model, which is presented first in the published paper, and second, a conceptual framework designed and described as a toolkit.

Chapter 7 explicates the findings through the discussion chapter, summarising and integrating the findings from the four findings chapters into a meaningful whole. The use of several text-generation strategies under an overarching hermeneutic methodology is justified by setting the findings against the aims of my study. The discussion explains the ways the methods and the findings were part of my transformation and that of the participants. Each of the findings is placed within a clinical-supervision framework that can be used to implement new, or evaluate current, supervision. As is expected in a professional doctorate, the findings in this study are applicable to the health workplace, as the research was based within that environment.

Chapter 8: Conclusion, is the concluding chapter: it outlines the findings and products of this study and specifically describes the original and significant contribution the study makes to allied-health clinical supervision. This chapter concludes the exegesis and explores the implications of the findings in relation to allied-health experiences, identified clinical-supervision needs, new tools for enacting clinical supervision and suggested opportunities for future research. The outcome is a clinical-supervision framework that reflects the supervision needs of allied health. The framework is discussed in the context of a health organisation. I present the implications of this as a practical tool for the implementation and evaluation of allied-health clinical supervision programs.

1.9 Portfolio

The Doctor of Health Science requires an exegesis that includes an attached portfolio. The portfolio contains documents evidencing the
researcher’s scholarly work and can include conference papers, reports, policy documents and plans (Charles Sturt University, 2015). The portfolio is attached to the exegesis as a separate set of documents to demonstrate professional and academic development across the course of the research. The portfolio includes an independent table of contents that reflects the research and knowledge development across the doctoral candidature. I use cross-referencing from the exegesis to the portfolio to strengthen my demonstration of where I have advanced or contributed to the area of clinical supervision in allied health.

1.10 Chapter Summary

My experience of facilitating a clinical-supervision policy in a health-practice environment led to the research journey described within this exegesis. The health organisation acknowledged the importance of clinical supervision and responded with a request for a structured approach to the initiation of clinical supervision for allied health.

I found that the available research supported a structured understanding of clinical supervision as a way of achieving consistency of quality and implementation. I located abundant discussion about the importance of clinical supervision in the general health environment; these studies suggested key elements to consider. Despite this, the research landscape was lacking volume about specific requirements for clinical supervision in allied health. These gaps in the understanding about allied-health clinical supervision and the need for a supervision policy compelled me to understand the specific needs of allied health in clinical supervision. This understanding could then inform the overall conception and direct implementation of clinical supervision within the health workplace.

A qualitative research approach was well placed to achieve a deep understanding of clinical-supervision needs in allied health, and was instrumental in applying the new knowledge both theoretically and practically within the workplace. Whilst the study was guided by a hermeneutic methodology, action research played a key role in the
development of the clinical-supervision policy, and thus the study as a whole. Action research provided a structured platform for the deeper thinking and hermeneutic interpretation of the clinical-supervision experiences at the core of this research, giving space for the practical to enter the theoretical sphere and creating a connection across the study between thinking, meaning and acting.
CHAPTER 2: METHODOLOGY

2.1 Introduction

In Chapter 1, I outlined the need to develop clarity and structure for allied-health clinical supervision. In this chapter I present the study’s methodological paradigm, method, participant selection and recruitment strategies, giving an explanation and rationale for the philosophical framework and methodology. I describe strategies for text construction and text interpretation to provide a background to the structure and sequence of the study. I present ethical issues to clarify steps taken to ensure rigour throughout the study. I then describe the three types of texts and the strategies I used to generate these, and the text interpretation within the research text sets to clarify the iterative nature of the study and the appropriateness of my chosen methods. I conclude the chapter by summarising the integration of the text-construction approaches as a foreword to the presentation of the findings in the following chapters.

2.2 Purpose of the Research

The first goal of this research was to develop a deep understanding of the supervision experiences of allied-health professionals in a public-sector workforce. Informed with this understanding, the second goal was then to develop an approach to clinical supervision and policy development within the public-sector health context that would have the potential to improve the quality and consistency of clinical supervision in allied health. To achieve this goal a number of research questions were posed to guide the research.

2.2.1 Research questions

The overarching question for this research was: What are the clinical-supervision experiences within allied health and how can these be used to develop tools for practice and implementation?
Specific research questions that guided the research process were:

1. What are the clinical-supervision experiences within allied health?
2. Are these experiences important when forming a clinical-supervision policy?
3. Can action research be used as a tool for clinical-supervision policy development?
4. Can action research affect policy development for implementation?
5. How can an understanding of allied-health clinical supervision needs and experiences be built upon, to provide a foundation for future clinical supervision?

The research questions guided me in my choice of philosophical framework, methodology and methods. The following sections detail the research structure, approaches and decision-making as guided by these research questions.

### 2.3 Structure of the Study

A qualitative approach was most appropriate for this study, as I sought to understand clinical supervision from allied-health clinicians’ personal experiences. Using inductive reasoning, qualitative researchers begin with details of a human experience, then move to a broader picture (LoBiondo-Wood & Haber, 2006, p. 11). Figure 1 illustrates the overarching place of the qualitative research approach in the structure of my study and the methodological and philosophical perspectives I chose in alignment with this approach.
From the array of qualitative approaches, I chose an interpretive research paradigm for two reasons: first, it focuses on people and the way they interpret or make sense of reality; and second, it examines the context in which the studied phenomena occur. Using an interpretive paradigm, a researcher seeks to understand specific experiences within the world in which they occur. Thus, I constructed an understanding of the experience of clinical supervision in the context of allied health as a group, set within the healthcare workplace. My choice of text-construction strategies facilitates exploration of the views and beliefs of participants to develop a deeper understanding of clinical supervision in a health context. Both the qualitative research approach and, within it, the interpretive paradigm framed the approach to developing new knowledge and making decisions.

Within the qualitative approach and interpretive paradigm, I chose a philosophical hermeneutic methodology. Further reference to philosophical hermeneutics for the remainder of the exegesis will use the term hermeneutics. A hermeneutic paradigm enables researchers to describe human experiences as consisting of multiple realities and
perspectives rather than as the embodiment of a single objective reality (Guba & Lincoln, 1989; Vandermause, 2008). The nature of a particular situation or experience is relative to those experiencing the phenomenon, who are best placed to reveal and agree upon shared experiences (Guba & Lincoln, 1989). The study of the shared experience and recognition of the significance of the experiencer is consistent with hermeneutic methodology, making it appropriate to apply to the clinical-supervision experience.

The role of the hermeneutic researcher is to “translate…understanding of experience into language that in turn, can build and create a practice” (Vandermause, 2008, p. 70), thus presenting the interpretation or new understanding in a translatable and understandable form. I sought to translate the clinical-supervision experience of allied-health clinicians into language and text that built a clinical-supervision policy. I further translated the clinical-supervision experience, which resulted in the development of several tools for the enactment of clinical supervision.

Hermeneutics contains a number of philosophical elements that may be applied in the conduct of research, in both design and interpretation. In this study these included fusion of horizons, the hermeneutic circle, prejudice and preconceptions, questioning the texts and the use of language and texts (Linge, 2008; J. Smith, 2007). The following paragraphs explain these concepts.

Language and text are important tools for understanding in hermeneutics: they are the way that meaning is shared (Crotty, 1998). Hermeneutics has moved away from its historical origins of interpreting biblical texts to include a wider source of texts (Crotty, 1998). Hermeneutic interpretation can be applied to a range of texts, including written material such as textbooks, interview transcripts, poetry, diaries, journals, logs, non-written material such as art, music and film and others such as observation and recorded materials (van Manen, 1997). In my study, texts were constructed from audio recordings, conversations and written text emerging from the study, including my understanding and knowledge of
and reflections on the research process. I applied hermeneutic interpretation to each of the constructed texts.

The diverse nature of the research questions led me to construct a range of texts for interpretation. The three key text sets were literature, experiential and synthesis (Figure 1). These text sets were the means by which I interpreted the participants’ experiences and arrived at my findings. Figure 1 shows the text sets as three key research points within the structure of the study.

The literature text (Chapter 3) was constructed by engaging with literature, health professionals and texts, and reflecting on my own notes and understandings. Next, I asked participants to complete a survey (Appendix 1) with a further option to engage in an action-research process. The survey results were used to develop a clinical-supervision policy. The survey responses, the recordings of action research group meetings and my field notes comprised the experiential text set. The third text set was a synthesis of all texts (Chapter 7). Synthesis is defined as “the process or result of building up separate elements…into a connected whole…” ("Australian Concise Oxford Dictionary 5th Ed," 2009, p. 1463). In the synthesised text set I combined all text elements and understanding, and interpreted them as a meaningful whole. This is consistent with the hermeneutic circle.

Yanow (2006) described the hermeneutic circle as a movement of interpretation and understanding from the part to the whole and back again within a multitude of meanings and interpretations. The function of the hermeneutic circle is to begin with a sense of the whole meaning of the text and revise this meaning as a researcher engages with specific parts of the text (Grondin, 2002). I used this process in my study, moving from the broader picture of my understanding of the whole study and its meaning, back to the details of the text being interpreted. Repeated engagement with the texts facilitated a circular movement to and from the text, with me as the interpreter. The hermeneutic circle can also be seen in the structure of the study. The many text types and text-generation
strategies each gave me the opportunity to engage with the texts as individual parts, and yet challenged me to understand the meaning of the study and clinical supervision as a whole (Figure 1).

The flow of the texts began with the literature text, moved to the experiential text and finished with a synthesis of all texts. This enabled a building of knowledge and understanding from each text to the next. This progression is consistent with a hermeneutic fusion of horizons, where the understanding or horizons of the researcher are integrated with that of the phenomenon being studied (Dowling, 2007). The importance of the fusion of horizons for my study is the connection between my pre-understanding before the start of the hermeneutic circle and my new understanding from the text. I interpreted the text within the context of this pre-understanding and encountered a broadening of my own horizon from the text. The new understanding is a fusion of the horizon projected by the text with my own earlier understanding.

The knowledge I brought to the research as an individual is considered by Gadamer to define my standpoint, which is where understanding begins (Gadamer & Linge, 2008). This understanding is considered to contain my own prejudice and preconceptions about clinical supervision. It was my role as researcher and text interpreter to acknowledge these biases and ensure that I was open to the messages, questions and intuitions emerging from the text (Alvesson & Sköldberg, 2009).

It was important to listen to the text as it posed questions to me, and, in turn, to my questions to the text (Lawn & Keane, 2011). “The central task of the interpreter is to find the questions to which a text presents an answer; to understand a text is to understand the question” (Bleicher, 1980, p. 114). I repeatedly engaged with the text using a variety of techniques: reading the text as a whole, noting broader and more detailed themes as they emerged and using visual representations of text. These techniques ensured that I was open, as Bleicher suggests, to emerging questions from the texts. In this way, as the interpreter, I remained ready
to question and be open to unanticipated understandings as a result of engagement with the text, as suggested by Vandermause (2008).

2.4 Rationale for the Use of Hermeneutics

Hermeneutics has been used as a research strategy in a number of health-related studies. Studies that used hermeneutics examined professional practice (Paterson & Higgs, 2005), aimed to understand the experience of mentoring for nursing leadership (McCloughen, O’Brien, & Jackson, 2009), and applied it as a methodological device for health research (J. Smith, 2007).

I used hermeneutics as a methodology for four reasons. First, hermeneutics is a highly reflexive method requiring acknowledgment of my pre-existing ideas and prejudice. This resulted in a deepening of my understanding about clinical supervision.

Second, hermeneutic research is situated in the context in which the phenomenon occurs. This ability to conduct the research within the health environment, where the experience and meaning of clinical supervision was located, was important in capturing the essence of the clinical-supervision experience (J. Smith, 2007; Vandermause, 2008). Conducting research in the health environment facilitated a shared understanding of experiences and the need for actions based in practice.

Third, the fusion of horizons demonstrated the old and the new in a constantly changing interpretation (Gadamer & Linge, 2008). Understanding my past horizons and the horizon of the text was an important part of the journey into a co-determined meaning or new horizon, a concept discussed by Sharkey (2001). Reflective diarising clarified my own horizons, and the creation of participant texts clarified the participants’ horizon. Hermeneutics enabled me to acknowledge my past experiences and understanding, and ensured that the horizons of the participants became overt and discernible in the recognition of new horizons.
Finally, the task of creating a clinical-supervision policy was based in practice, and was best placed to be informed by those participating in the research. Hermeneutics was well positioned to understand the experiences of individuals that were inclusive of the values of and beliefs of the participants and myself as the researcher. Hermeneutics is based in the belief that there are multiple ways of experiencing and understanding phenomena such as clinical supervision (Guba & Lincoln, 1989; Vandermause, 2008).

2.5 Participants

2.5.1 Participant sampling and inclusion criteria

Sampling for qualitative research is for a specific purpose and requires the selection of populations that illustrate specific issues or situations (Polgar & Thomas, 2008). The sampling in this study was non-probability purposive sampling. Purposive sampling involves sampling for examples of a particular situation; information-rich populations are sought (Grbich, 1999; LoBiondo-Wood & Haber, 2006). I chose allied-health participants who were experiencing clinical supervision, thus ensuring the participants had specific knowledge of the phenomenon under investigation.

Participants were included if they were an allied-health clinician as defined by the New South Wales Health, Health Professionals (State) Award (New South Wales Health, 2007). This employment award was chosen as a criterion because it encompassed most allied-health professions and made parameters for participants’ self-selection very clear. The award includes the following professions: audiologists, art therapists, counsellors, dietitians, diversional therapists, exercise physiologists, genetic counsellors, music therapists, occupational therapists, orthoptists, orthotists/prosthetists, physiotherapists, play therapists, podiatrists, speech pathologists, social workers, sexual-assault workers and welfare officers.
Participants were also required to have had experience with clinical supervision as either a supervisee or supervisor. Both supervisor and supervisee perspectives were essential to explore supervision policy from both sides of the supervisory dyad. I did not specify a minimum amount of clinical-supervision experience in the selection criteria as listed below. This was to ensure that participants along the entire supervisory spectrum were included.

A supervisee was defined as any allied-health clinician who had received supervision in any form, including mentoring, coaching and peer-to-peer and group supervision. No definition of clinical supervision had been established within the health organisation; thus the study was free to develop one with participants. Using a narrow definition may have resulted in participants self-eliminating from the study.

A supervisor was defined as any allied-health clinician who had provided supervisory activities, as described above for supervisees.

2.5.2 Context of participants

Participants were allied-health staff employed by South Eastern Sydney Illawarra, New South Wales Health (SESIAHS). Participants worked across all work settings, including community health, mental health and hospital-based services. SESIAHS, on the eastern coast of Australia, is one of eight Area Health Services within the state of New South Wales, Australia (Figure 3). The size of the catchment area for SESIAHS extends almost 300 kilometres south of Sydney, and includes metropolitan, outer metropolitan, regional and rural areas. I chose to include participants across a range of geographical locations so that the results of the study might similarly be applicable to a range of settings. During the study, I was employed by SESIAHS, which increased the ease with which I could organise the study. The inclusion of only one health organisation allowed for timely completion of the study; however, this may have limited the number of participants and variety of sites included in the study.
2.5.3 Recruitment

I provided potential participants with three options for their involvement. They could participate in an online anonymous survey only, in action-research groups only or in a range of modes, to cater for their preferences for anonymity or visibility and their time availability.

I distributed the invitation to participate using the Health Service email. I provided details about the two options (survey and/or action-research groups) within a single email, with instructions for participants wishing to participate in the survey only or action research groups only and for those wishing to participate in both (Portfolio 1.1.7).
2.6 Approaching the Construction and Interpretation of Text Sets

In Section 2.2 I presented the overall methodology and philosophical framework that shaped the research design. In the following sections I will present the detailed methods used to construct and interpret each text set. First, in Section 2.6.1, I will describe my overarching approach to text interpretation, which applied across all text sets. I used three approaches to the construction and management of text; I will describe the subsequent text construction and interpretation of each text individually (Figure 1).

2.6.1 Text interpretation

I used text interpretation across three levels. This process of interpretation was followed by Zimmer (2006) in an approach to hermeneutic meta-interpretation in qualitative research. This approach was applied by Zimmer to a set of qualitative studies in broadly the same way that a meta-analysis would be approached in quantitative studies. Zimmer described the goals of the meta-analysis, which were broadly applicable to my study, as “theory development, higher level abstraction, and generalisability in order to make qualitative findings more accessible for application in practice” (Zimmer, 2006, p. 313) Schlomann and Schmitke (2007) used Zimmer’s suggested approach to qualitative interpretation to conduct and interpret a synthesis of literature. In the same way, I applied Zimmer’s three levels of interpretation to the texts within my study to achieve a structured approach to higher levels of abstraction. From this I sought to develop possible theories or findings that would be applicable in practice and transferable across participants and contexts. Zimmer specifically framed the suggested meta-interpretation with hermeneutic elements, which also aligned with the method in my study.

I will broadly describe all three levels of interpretation before I give a more detailed explanation of my interpretation as applied to each text set. The first level is described by Zimmer (2006) and Schlomann and Schmitke (2007) as the conversations, behaviours and interpretations of participants. First-level interpretation was applied to the survey questions and the texts constructed within the action-research groups.
Conversations and participants’ interpretation of their own texts were considered first-level interpretation.

The second-level interpretation was my engagement with the first-level interpretation. This is where I examined the participants’ interpretation with an acknowledgement that my own experience and understanding influenced my interpretation. This occurred in the early interpretation of the survey text and outside the action-research groups.

Third-level interpretation occurs when a number of secondary interpretations are synthesised with consideration to the complex context in which the phenomenon occurs (Zimmer 2006). A meta-interpretation, which was consistent with this third level of interpretation, occurred chronologically after the first- and second-level interpretations had concluded.

![Figure 3 – Order of text interpretation](image)

Figure 3 shows the three levels of text interpretation. Levels 2 and 3 are built upon the interpretation and understanding of the previous level. With each level of interpretation I strove to create a deeper and richer understanding of allied-health experiences of clinical supervision. The concentric circles denote a surrounding of every understanding and interpretation that preceded and a fusion of horizons. This approach to the interpretation of texts uses the hermeneutic elements of acknowledging
prejudice and preconceptions, the hermeneutic circle and the fusion of horizons.

The three text sets generated in this study were the literature text, experiential text and synthesis of text. Each of these text sets as individual text points within the study had individual text-generation and interpretation processes. Thus each text point will be described separately, including a description of participants, type of text, why it was chosen, text generation and interpretation processes. The experiential and synthesised text sets were interpreted using several text-generation strategies each; this will be described in detail.

2.7 Text Set 1 – Literature Text

I considered two types of pre-understanding in the literature text: first, the understanding that I held prior to entering the research and engaging with participants, which included general knowledge about clinical supervision and an awareness of the growing importance of clinical supervision; and second, my understanding prior to structured engagement with formal literature or participants, which included general reading and researching about clinical supervision in a range of health professions. There was also the understanding I developed as I engaged with the literature text set, and prior to engaging with participants. I integrated the literature into my pre-understanding and produced a formal published literature review (Chapter 3).

Gadamer (2008) asserted that pre-existing knowledge and judgements were a part of interpretation. This is contrasted with the bracketing approach of setting aside one’s beliefs and history, as described by Husserl (Vandermause, 2008). Gadamer contended that hermeneutic interpretation is productive rather than reproductive, as it does not reproduce the author’s original intent, but rather allows the development of a new understanding (Gadamer & Linge, 2008). This new understanding includes both the text and the interpreter’s current situation and historical understanding, but is more than simply the sum of both (Sharkey, 2001).
Historical contributions to the philosophy of hermeneutics have arisen from the work of a number of philosophers, such as Dilthey, Schleiermacher, Gadamer and Ricoeur (Crotty, 1998). Schleiermacher and Dilthey viewed the interpreter’s own knowledge and values as a source of distortion that interfere with an accurate understanding, and are therefore something to be overcome (Linge, 2008). Gadamer built upon this concept by suggesting that the interpreter’s present situation acted as both prejudice and tradition, and that to ignore this is to risk being unaware of the effect they have on interpretation (Linge, 2008). Gadamer asserted that it is impossible for the interpreter to cast aside his or her pre-existing knowledge and experience, and described this as the “hermeneutical situation” (Linge, 2008, p. xv). Based on this, it was important to set down my initial understanding of clinical supervision, allied health and health leadership and management.

My initial understanding of clinical supervision in allied health was formed by my experiences as an allied-health professional spanning more than 20 years, and as a senior manager within health services for more than eight of those years. This experience led me to understand that each profession approached clinical supervision differently, and not at all by some. As I engaged with the emerging literature on clinical supervision I noted a paucity of allied-health-specific material. Paired with the emerging requirement within my health organisation, my motivation to understand what clinical supervision meant for separate allied-health professions broadened to a curiosity about allied health as a group. I then commenced a dialogue with health professionals and other senior managers that helped me realise the importance of addressing clinical supervision in a more structured way.

The first text set was a literature text set where I connected with the understandings that had preceded mine. This is consistent with the Gadamerian concept of historically interpreting in the context of the horizons that have existed before one’s own (Sharkey, 2001).
Gadamer argued that the interpreter’s current situation and understanding defines the interpreter’s standpoint, which is where understanding begins (Linge, 2008). Gadamer also considered the temporality of the interpretation as important, as the context of the interpretation and understanding is based in the interpreter’s, not the author’s, present time and understanding (Linge, 2008). Time, context and pre-understanding can all contribute to the interpreter’s preconceptions. I constructed the literature text set in my search for a deeper understanding of the experience of and need for clinical supervision in allied health. Examining current literature provided both a deeper understanding of clinical supervision and knowledge of what was already known and what needed to be known. The development of my pre-understanding commenced prior to the construction of the experiential text sets. I sought to frame my study with regard to what was already known about clinical supervision in a broad number of professions, and then to focus my understanding on what was known about clinical supervision in allied health.

2.7.1 Literature-text construction strategies

The range of literature I investigated included: academic papers, theoretical and educational texts on clinical supervision, course notes taken from clinical-supervision conferences that I attended, and policies and position papers from Australian health organisations.

The text set was drawn from a broad range of professions, including nursing and midwifery, psychology, medicine, physiotherapy, social work, occupational therapy, podiatry, nutrition and dietetics and counselling, and across a number of approaches such as health management, education, public health and qualitative research. The literature reviewed was obtained from a number of sources, such as online and print text books, the Joanna Briggs Institute and Cochrane libraries, EbscoHost Health, MEDLINE, CINAHL, PubMed and PsychINFO from 1920 to 2010. In a later review, I consulted the same literature sources using the date range 2010 to 2016. This later review occurred after the initial formal literature
review text, and I continued to add further texts and update my understanding of clinical supervision in allied health throughout the study.

In writing a formal literature review as a publication, I was required, first, to be critical of this literature; second, to structure and explain my interpretation and understanding of the information; and third, to comply with the mandate to publish in accordance with the requirements of a professional doctorate.

The production of a literature text set formalised my pre-understanding in a transparent process of learning and discovery. Participants were able to follow the journey to my current horizon and understand how I arrived there; this ensured that the interpretation process was open to challenge and questioning. These pre-understandings, consistent with hermeneutics were always shifting and renewing as horizons, and existed as one important part of understanding the whole experience of allied-health clinical supervision.

2.7.2 Literature-text interpretation

My interpretation of the literature texts included using hermeneutic principles. I challenged my pre-understanding with new understanding from the literature to form a fusion of horizons from the texts. My interpretation of the texts culminated in a formal published literature review text. This text is a reflection of my pre-understanding at that specific time as I clarified my knowledge and beliefs about clinical supervision, prior to generating and engaging with the experiential text sets.

I questioned the texts: what was clinical supervision, why was it supported and how did it work? I asked the literature, is this what clinical supervision is like for allied health? When reading allied-health-specific literature, I asked more-specific questions about the barriers and important issues and inclusions that affect clinical supervision. This questioning of the texts is consistent with the hermeneutic element of engaging in a conversation with the text through asking the right questions (Sharkey, 2001). Chapter 3 presents the results of this process.
2.8 Text Set 2 – Experiential Text

The second text set was constructed from the participants’ experiences and perceptions of clinical supervision; this was appropriate, given that participants were engaged in a practical clinical workspace wherein the experience of clinical supervision was situated. An interpretive paradigm accepts the existence of a range of understandings of each human experience; therefore, I used a range of health professionals and strategies to elicit a variety of experiences. The second text set was created from the anonymous survey, my handwritten and typed notes from action-research sessions, my interpretations and reflections on the action-research sessions, audio recordings of action-research groups, documentation in the form of a policy and a series of five newsletters (Portfolio 2.3).

The following sections describe the two processes employed to generate the experiential text: an anonymous survey and a series of action-research groups. Each section will describe the processes in which participants were engaged to generate the texts, and will follow with descriptions of the steps taken to interpret the texts’ meaning. I will describe the action-research process in detail, as this was an important part of the construction of the policy text. I will clarify the steps taken to demonstrate transparency, showing that consistent techniques were used.

2.8.1 Generation strategies experiential text set – an anonymous survey

The first text of the experiential text set was generated from a survey of all allied-health staff within the health district. The survey was open to staff for four weeks. Surveys are an important tool in health research to establish opinions, beliefs or attitudes around a specific issue; however, the survey may not represent all views or have results that transfer to other populations (Drummond, Sharp, Carsin, Kelleher, & Comber, 2008; Halbesleben & Whitman, 2013; Polgar & Thomas, 2008). It was thus accepted that although this text may not be broadly transferable, it could
describe and summarise the experiences of the survey participants in clinical supervision.

The survey provided a quick method of accessing a wide range of participants in SESIAHS. The survey was a catalyst for ideas about clinical supervision to be considered by the action-research groups. The survey, which was designed to seek participants’ experiences of supervision, was made available to all allied-health staff through the internet survey tool Survey Monkey. It contained seven questions:

1. How many years have you worked in your professional field?
2. Do you consider you have more experience as a supervisor (one who supervises) or supervisee (one who is supervised)?
3. Please provide a short description of an experience you have had with clinical supervision. Your story should contain enough detail so that we can understand the situation and any issues. Describe the actions of those involved and explain what the outcome was.
4. Are you aware of any problems that exist in your area in relation to clinical supervision?
5. How do you think policy on supervision would affect your experience of supervision?
6. What three factors do you consider most important to the process of supervision?
7. Do you think it would be helpful to have a whole of allied health approach to clinical supervision?

The survey was completed anonymously to facilitate greater disclosure of participants’ thoughts and feelings. Power differentials are innate to clinical supervision (Patel, 2004; Rose & Best, 2005). This power difference needed to be acknowledged as a possible barrier to open and
honest participation, due to fear of repercussions. I chose an anonymous survey to manage the effects of perceived power differences, which encouraged honest and open participant engagement and a wider example of experiences to incorporate into the aggregate texts.

2.8.2 Text interpretation – survey

The survey produced two kinds of information. First, it gave answers to questions with categorical information aimed to achieve a quick understanding of participants’ supervision background and opinions. The purpose of these questions was to present the information to the action-research groups to achieve a shared identity with survey participants and to provide stimulus for initial discussions. Categorical results were presented quantitatively using the survey tool. However, all information was interpreted within a hermeneutic methodology; for this reason I have not labelled this study as mixed-method. It was important that the action-research group participants made their own sense of the meaning of the survey information to relate to the experiences and the survey participants. For example, in presenting the percentage results for Question 4 (Appendix 1), I asked the group participants, “What does this mean to you?”

The second kind of information generated was free text about participants’ experiences of supervision. These questions were interpreted in a hermeneutic process, and the understanding I had gained from the categorical information was integrated into this interpretive process. I presented the responses from the free text using frequency ranking. This process is not usually placed within a qualitative research space. I interpreted these questions, however, using hermeneutic principles, which are explained in the steps below. I presented the frequency ranking from themes that I had identified as a result of early hermeneutic interpretation, as this was an easily interpreted format for participants and could indicate the strength of the identified themes (Portfolio 2.3.1)
The interpretation of the survey texts was completed over the two-week period between the survey closure and the commencement of the action-research groups. Following are the steps I took to interpret the survey information.

**Step 1: Immerse myself in the texts.**

I read the texts multiple times to ensure an overall sense of the whole. I underlined what I considered to be key words in each response and used these words as initial ideas or concepts that emerged as early labels or categories, a process recommended by Graneheim and Lundman (2004).

<table>
<thead>
<tr>
<th>Highlighted phrase</th>
<th>Sub-category</th>
<th>Main category</th>
</tr>
</thead>
<tbody>
<tr>
<td>When supervised, private information was disclosed to another person without my permission; as a result all trust was lost in the supervisor.</td>
<td>Trust in relationship essential to good supervision.</td>
<td>Relationships</td>
</tr>
<tr>
<td>Supervision is focused on the needs of the supervisee adopting a similar framework to Kadushin…. Supervisor is a clear advocate on supervisee’s behalf to management or other professionals.</td>
<td>Clear about how it should look and supervisor role.</td>
<td>Definition</td>
</tr>
<tr>
<td>Throughout my new grad year I was initially provided with supervision and guidance as needed…. Since then I…only seek supervision when a new skill is required….</td>
<td>New grads have supervision embedded in their everyday work.</td>
<td>Embeddedness</td>
</tr>
<tr>
<td>Recipient and provider with clinical and non-clinical supervisor. Positive experience.</td>
<td>Giver/receiver. Positive experience</td>
<td>Giving or Receiving</td>
</tr>
</tbody>
</table>

*Table 1 – Preliminary interpretation*
Step 2: Make note of significant statements and important ideas.

Upon a second reading of the text I noted repeated words and phrases that I thought described interesting or surprising ideas.

Step 3: Create meanings from each important statement or idea and choose categories or labels for them.

I read the text and created labels or categories that best represented the meaning of the text. This meant that I was using the understanding I had gained from the literature text set and the immersion and note-making from the interpretation of Levels 1 and 2. I placed the labels in tables in chronological order so that I could visually interpret them. I then connected labels by grouping them into categories where they described similar ideas or concepts. Creswell (2013) describes capturing the essence of a phenomenon, or the common experiences of participants; in this way, Step 3 aimed to express the essence of participants’ experiences.

Step 4: Connect categories and labelling emerging themes when common ideas and concepts were identified.

This step demonstrated my use of the hermeneutic circle, moving from narrow to broader, more inclusive categories as I increased my understanding of the text.

Table 2 demonstrates the process I undertook in Step 3 for Question 6. Survey participants were asked to state three factors they considered important to the process of clinical supervision. First I highlighted sub-categories (column 1), then I formed narrower generic categories (column 2). I then constructed themes (column 3) that explained all categories in columns 1 and 2. The aim of a theme is to give shape and focus to the meaning of the experience (van Manen, 1997).

Table 2 illustrates the highlighted sub-categories (column 1) such as “regularity”, “set intervals”, “frequency” and “regular time allocation”. Each of these sub-categories was explained by the category of “regularity of
clinical supervision” (column 2). Each category (column 2) was then examined with consideration given to similar categories, such as “accessibility”. In this example both accessibility and regularity, when described as being absent, were deemed to be threats or barriers to clinical supervision. The main category themes were presented to the groups with sample stories from the survey text; they served as a scaffold for identifying essential inclusions in developing key principles for clinical supervision.

<table>
<thead>
<tr>
<th>1. Highlighted sub-category</th>
<th>2. Category</th>
<th>3. Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regularity</td>
<td>Regularity</td>
<td></td>
</tr>
<tr>
<td>Set intervals</td>
<td></td>
<td>Challenges or threats to supervision</td>
</tr>
<tr>
<td>Frequency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time allocated regularly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accessibility</td>
<td>Accessibility</td>
<td></td>
</tr>
<tr>
<td>Time in a working day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Availability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to supervisor</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Table 2 – Early categorisation to themes**

**Step 5: Illustrate early themes.**

Once I had generated themes for the responses to each question, I listed them. I again read the text as a whole, questioning the text with these themes. When I identified a category that fitted within that theme, I noted the place in the text where the category occurred against the theme. This was a reflection of my interpretation of the ability of the themes to explain and capture the clinical-supervision experiences. The resulting list had the qualities of a frequency graph, and I used this as a visual report to participants of the breadth and strength of the themes against each question. This was also allowed me to convey my interpretation
transparently, as the participants were not familiar with hermeneutics as research concept. My interpretation also served as an early feedback of responses, which was distributed to the allied-health group through a newsletter format (Portfolio 2.3.3 & 2.3.4).

**Step 6: Write an exemplary narrative.**

I constructed exemplar descriptions to illustrate archetypal understandings of the participants’ experiences (Portfolio 2.2.5). These case stories were a combination of different participants’ experiences that exemplified the themes I had interpreted in Step 5. These narratives aimed to give a cumulative experience to the survey participants, which I hoped would facilitate a connection from the action-research group participants to the survey participants through these blended clinical-supervision experiences.

### 2.9 Action Research – Constructing a Clinical-Supervision Policy

After the survey, I recruited participants to the action-research groups. Action research in this study was used as a tool for policy construction in a practical context, providing participants with a tangible outcome. Action research also functioned as a text-construction strategy to enable an understanding of the experience and needs of clinical supervision in allied health, meeting the aims of my study. For this reason I have dedicated a large section to explaining and describing the action-research process and the philosophical and methodological reasons for its use.

The timeframe for the policy development process was 10 weeks. This meant that participants attended a group session every two weeks. I chose this timeframe as I thought it would be an achievable attendance for health professionals, allow me to facilitate all groups within the timeframe, give me adequate time to interpret information from one group to the next and deliver a policy in an acceptable period of time.
2.9.1 Action research – a philosophical, methodological and practical choice

Action research has not traditionally been paired with hermeneutics because they differ philosophically and methodologically (Smits, 1997). Hermeneutics is based in how a lived experience is understood, not in an explicit method, whereas action research is based in both method and understanding lived practice (Smits 1997). Smits (1997, p. 288) proposed a “hermeneutically inspired action research”, a shared research space between action research and hermeneutics.

Smits highlighted the importance of language in hermeneutics, to which conversation is central, and suggested that action research creates a space for conversation about understanding practice. Conversations were critical to the action-research groups in my study, as it was key to building relationships within groups. Agreed language was the way in which conversations were transported across groups. This language in turn created texts for hermeneutic interpretation.

Action research enables access to participants’ pre-existing views, through sharing their understanding of what is known about the experience and of current and future horizons (Smits 1997). This is consistent with the hermeneutic concepts of pre-understanding and prejudice as well as the fusion of horizons (Section 2.3). In my study this occurred as a sharing between participants about what was known and had been experienced in clinical supervision, a look to past horizons, an understanding of current horizons of clinical supervision and a practical emergence of future horizon through a clinical-supervision policy.

Lincoln, Lynam, and Guba (2011, p. 100) describe combining or interweaving philosophical and methodological qualitative viewpoints as a “bricolage”, suggesting that it can enhance the richness of a study and increase the impact of future qualitative research, with specific mention of policy formulation. I chose action research under a hermeneutic methodological umbrella as a way to bring together the theoretical and practical aspects of clinical supervision. Gadamer and Risser (1979)
highlight the risks of theorising on practical issues of daily life and, conversely, the dangers of narrowing one's view to a solely practical focus. Thus I considered action research to be the practical reasoning and application that Gadamer and Risser (1979) consider necessary for practical decision-making, and a link to the broader theoretical view of hermeneutics – a link between theory and practice.

Given the strong motivators for this study – the need for a clinical-supervision policy and a clinical supervision structure and the need to include allied health professionals in the design and development of clinical supervision practice – it was important to work within the clinical-supervision space with participants. Action research also enabled the bottom-up approach to policy development identified in Chapter 1. This moved me from the role of expert researcher to co-researcher, which enabled me to understand the meaning of the clinical-supervision experiences from within the allied-health professional collective.

2.9.2 Action-research cycles

Action research focuses on changing practice through a repeating spiral between reflection and action (Creswell, 2007). This trialling of one action and continually returning to the question of what has been learnt by the action is clarified by through Stringer’s (2014) Action Research Model. Stringer simplifies the method into three phases – Look, Think and Act – which I adopted for this study.

The group process in this study was structured by the action-research elements of look, think and act within each cycle. A cycle was the transition through the three elements within one session. The group members determined how much time was spent on each element in each cycle. As the group facilitator I encouraged the group to keep moving through the sequence of look, think and act; however, I aimed to allow the participants to direct the timing by asking questions focusing on each phase: for example, “What does that look like?” “What does that mean?” or “How could you make that happen?”. There were five cycles or group
sessions over a period of 10 weeks. Figure 4 illustrates the repeating cycles of action research.

![Figure 4 – Action-research cycles](image)

**LOOK**

First, the participants *looked*. They built a picture of the current issues in allied-health clinical supervision, which included defining the current problems and barriers to supervision success. This was achieved through gathering of information, recording ideas and interpreting results of the survey, which were presented to the groups as charts, graphs and vignettes.

**THINK**

Second, the participants *thought*. The *Think* element employed interpretive processes to facilitate participants' understanding of issues; they then prioritised these issues for action. Problems were also interpreted in this phase. I presented the collated texts that had been interpreted in the *Look* phase to the groups for consideration and re-interpretation. The participants then identified, confirmed and prioritised the issues. The priorities identified in the *Think* phase were matched to an action or practical solution.
Third, the participants acted, which is not the final phase, as action research is a process of continual reflection and action. The participants implemented practical solutions to problems that were identified through the Think element. Participants examined practical aspects of implementation, documented a plan and made priorities. Action took the form of developing principles, guidelines and policy for clinical supervision.

Each of the five cycles had a specific focus.

**Cycle 1 – Review survey text, identify important issues**

The first cycle of the group focused on the presentation of my findings from the survey (Appendix 1). I read aloud exemplar narratives from the survey participants. Cycle 1 was also used to introduce the action-research process, the group process and the expected outcome and timeframes. In this cycle, it was important for me to present the opinions and issues that were discussed based on the results of the survey. During this cycle participants reflected on how their own supervision experiences compared to those that were being presented from the survey. Participants also used these reflections to illustrate important points to consider for inclusion in the principles for clinical supervision. A newsletter summary was sent to all allied-health staff (not only those participating in the action-research groups) after each group cycle and before the next planned cycle.

**Cycle 2 – Revise and refine identified issues into principles**

I interpreted and integrated notes and audio recordings, searching for common themes for principles from Cycle 1 that were common across all groups. During Cycle 2, I presented the themes to each group. Broad principles for clinical supervision were developed in Cycles 1 and 2. In each subsequent group of this cycle, the principles were refined. This resulted in a dynamic policy text because each group within the same cycle progressed the development of the supervision principles. The
participants built on the outcomes and discussions from the two other groups within the same cycle, which were conveyed by myself and the developing policy text. Figure 5 shows the three geographical location of the groups, which required me to act as the conduit between each group during each cycle. I also presented an empty policy template to the groups; the group members themselves specified what was acceptable to the group in terms of headings and sequencing, and used these policy headings as a broad structure for the emerging policy text.

![Diagram of geographical action-research groups]

**Figure 5 – Geographical action-research groups**

*Cycle 3 – Revise and refine principles, develop guidelines*

After taking the outcomes from group to group, I typed the principles as the groups had directed and sought refinement and acknowledgement from each group. The focus of Cycle 3 was then to develop practical guidelines for implementing the supervision principles. Similarly to Cycle 2, the guidelines were progressively formed during group discussion; I presented a summary of the discussion from each group to subsequent groups. In subsequent groups, participants reflected and discussed the previous group’s formulations. Participants often voiced similar concerns and ideas from group to group (Chapter 5).
Cycle 4 – Revise and refine guidelines, begin to formalise policy

Based on the discussions in Cycle 3, I created a document that summarised the group’s ideas and instruction on how each guideline could be practically implemented. Participants revised and refined the guidelines in Cycle 4. There was now a focus on the policy document resulting in discussions having an emphasis on the practical application of the policy.

Cycle 5 – Review and finalise policy, close research process

Prior to Cycle 5 I met with a policy representative from the health organisation to discuss the required format of the policy, which was necessary to comply with the Health Service governance requirements. I communicated the feedback from the policy representative to the groups, the outcome of which is discussed in detail in Chapter 5. The groups decided on a plan to integrate the suggestions from the policy representative and any final comments from group participants and send the final policy draft for comment to all allied health through the allied-health heads of discipline in the health organisation. Cycle 5 was also used to finalise the group cycle and receive any feedback about the groups, process or policy. Participants in this cycle also shared positive reflections about the groups and the potential for the work to affect clinical supervision.

2.9.3 Experiential text – construction in two contexts

Experiential texts were constructed within two contexts: inside and outside the action-research groups. Texts used and constructed within the action-research groups included results and extracts from the survey, audio recordings of the groups and handwritten field notes in which I recorded my thoughts and impressions, emerging themes and topics throughout the groups. I also wrote observational notes and explained this within the induction process at each group.
I used all texts constructed within and outside the action-research groups for my interpretation outside of the groups to prepare texts for the next group. Texts constructed outside the groups also included my written personal reflections in a diary. Reflective topics within my diary included group dynamics, emerging themes and categories, my performance as a facilitator and any possible influence I imposed upon the group as a researcher. A key text constructed outside of the action-research groups was written sections of the policy that had been created within each group, requiring me to collate and consolidate each group session.

A digital recording device was used, with consent and visible to all participants. The use of the recording device was also explained in the participant information sheet and included in the consent documentation and process (Portfolio 1.1.6). I reviewed the audio recording within two days of each cycle. I chose to repeatedly listen to audio versions of the groups rather than analyse a written transcript. This frequent listening facilitated my immersion in the text through identifying aspects of the conversation, such as vocal tone and mood that may not have been obvious in a written transcript.

During the groups, each participant was given pen and paper with which to make notes. Participants were encouraged to write down any issues they may not have felt comfortable discussing with the group. Participants were instructed to place this in a box provided upon exiting the group, which was clearly marked and placed onto a vacant chair adjacent to the exit. At the end of each cycle I checked the box. This allowed for additional, but de-identified, contributions from the focus-group participants. No participants made use of the box.

2.9.4 Interpretation of text from the action-research groups

Level 1 and 2 interpretations – an interpretive spiral (Figure 3)

The cyclical nature of action research ensured that text interpretation occurred at all points throughout the research groups. The interpretation of agreed actions constructed ongoing policy texts. This made the processes
of text construction and interpretation in the action-research groups difficult to separate inside the groups.

*Level 1 text interpretation – The groups’ developing understanding*

Level 1 text interpretation occurred first, following my presentation of the survey text to whole of allied health in the form of a newsletter. The action-research groups then interpreted the survey text within the action-research processes of look, think and act. I shared each group’s interpretation across all groups.

Allowing the participants to see the developing policy as a shared text across the action-research groups established a shared point of interpretation and progressive analysis. Thus, as one group interpreted an emerging problem and suggested actions, the next group would re-interpret these suggested actions. In this way action research was a constant cycle of text construction and interpretation and part of the hermeneutic circle of new understanding and fusion of each group’s horizon. The findings emerged using the iterative nature of action research to test themes within and across groups. The action-research process thus informed important group decisions, such as the essential inclusions in the overarching principles that were key to ensuring that the policy met all the needs of allied health.

The decision-making process occurred through participant questions and groups sharing and comparing supervision experiences as a way of testing whether the principles had covered all needs. One option for the groups was to revisit decisions based on additional information or emerging questions, which they did frequently as they further understood each other’s experiences and needs.

The movement between the first and second levels of interpretation was not linear: the cyclic nature of the action-research process resulted in repeating cycles for the duration of the action-research groups. An action-research method structured the group process as well as the text constructed within the groups. I used hermeneutic techniques outside the
groups in the second level interpretation to create a deep understanding of the allied-health clinical-supervision experiences and to contribute to my horizons for level 3 interpretation.

**Level 2 interpretation – my developing interpretation as the researcher**

My approach to interpreting the available texts was an integration of my understanding to that point in the research; that is, an integration of the literature text set and all available texts inside and outside the action-research groups. My role from cycle to cycle, group to group, was to integrate texts as decisions were made within each group. However, often broad decisions were made or a range of opinions voiced which required interpretation to incorporate them into a workable policy text. Where consensus had not been reached, I would clarify the issues, using questions as a focusing lens first, to clarify, and second, to ask for possible solutions. One example detailed in Section 5.2 was a discussion and first-level interpretation about the nature of documentation that should occur for clinical supervision. There was a healthy discussion, with differing voices and opinions heard; however, no decision was reached by the end of the session, though many ideas were put forth. As interpreter and facilitator, I felt it was my role to become a clarifying lens and capture those voices and opinions. I immersed myself in the recording to clarify my understanding of what had transpired. This was important because I was required to move all discussions across all three groups within each cycle. I was able to locate text within academic literature to share with the groups. As an example of a second-level interpretation, I also collated the solutions articulated by the groups into the organisational policy formats, which were then reviewed and discussed across the groups. To avoid the possibility of leading suggestions, I consistently asked the groups, “Is this what you meant by…” and explained what I had heard and written. I shared my reflections and second-level interpretive processes with the group, to give the participants access to the interpretation that had occurred.
Following is a detailed description of the second-level hermeneutic interpretive processes. This occurred through myself as the researcher, both inside and outside the groups, and describes the way my interpretation was conveyed to and from each group. This contributed to the groups’ ability to complete the work within the set timeframe, and to my understanding of the clinical-supervision experience as a whole. More formally, I examined all available texts within the context of each cycle and the questions and themes that arose from each. I have adapted several methods of text interpretation, from the eight steps described by Crotty (1996). I used this approach to ensure that a rigorous interpretive process was applied consistently to each cycle and group.

**Step 1 – Immersion in the texts**

I immersed myself in the texts by listening to audio recordings on repeated occasions: within two days of the recording to prompt personal reflections that occurred within the groups, and repeatedly throughout the five cycles. I read the texts constructed from the groups, as well as my own reflections, whilst I listened to the recordings to ensure that I was engaging with the whole meaning of the text. In this step I used a highlighter to highlight sections of text that were meaningful, interesting or relevant and made notes in the margins about possible meanings.

**Step 2 – Making note of significant statements and important ideas**

During my review of texts from the groups I would note specific statements, words or ideas that I found to be inconsistent with my identified significance or meaning, and would question the text as to why this occurred. One example of this was following the group session where changes to the policy wording were introduced to the group as a result of suggestions from an organisational policy consultant (Section 5.2). I had anticipated that this would be a controversial discussion, given how carefully the words had been chosen and their importance to the development of the policy. Following this group session I followed each step in interpretation, looking carefully for any influence I may have had on
this process or any signs of disagreement or dissension. Questions I asked of the text included why there was such a difference in my understanding about what the text meant compared to the group’s actual response. This led to my understanding the groups and their ability to see the policy text as a whole, such that the specific words, once a whole in themselves, were now just a part of the text as a meaningful whole. This is consistent with a hermeneutic process.

**Step 3 – Creating meanings from each important statement or idea and choose categories or labels for these**

During this step, a process of abstraction was undertaken. Abstraction occurs when categories are constructed to form a description of the phenomenon (Elo & Kyngäs, 2008). In this study, this occurred as I used my personal knowledge and pre-understanding from the literature text set to understand the meaning of sections of text. This knowledge was integral to my interpretation of the text; however, the categories or labels I used were the participants’ words. This ensured that I remained focused on the words and concepts that were important to them and kept my own interpretations open to the ideas of others, as suggested by Ajjawi and Higgs (2007). This is further discussed in Chapter 7.

**Step 4 – Grouping categories when common ideas and concepts were identified**

Following the creation of labels, I formed categories to explain concepts that were similar across all three groups within the same cycle. This made the identification of broader themes and patterns clearer and more easily identified. I checked the themes against the group texts and I used the groups as parts to understanding a theme as a whole, consistent with the hermeneutic circle.

**Step 5 – Synthesising of themes into the policy text**

I presented themes to the groups as the next step in the policy-construction process and for feedback on appropriateness and
completeness, a process suggested by Ajjawi and Higgs (2007). I communicated my interpretations and understanding back to the groups in the policy text. A detailed explanation was important because the agreed outcome of the action-research process was a policy text. This was the groups’ turn for interpretation and synthesis, and my role as researcher was to listen and question. I asked questions to seek clarification of meaning and to elicit meaning that might be hidden from the participants, a process adopted from Ajjawi and Higgs (2007). An example occurred when I asked in several groups, “Is that important to you?” If the first question did not elicit the reason, I then asked, “Why is it so important?” Participants may not have thought deeply about a decision or words they were choosing and thus be able to explain or understand the impact that their past experience had on plans for clinical supervision in allied health. Questioning encouraged the groups to explore several topics more deeply, such as poor clinical supervision and difficulties seeking permission for time allotted for clinical supervision.

*Step 6 – Writing a descriptive explanation of the process and interpretation within a newsletter text*

Following each cycle, I was able to summarise Steps 1-5 through a descriptive explanation. This explanation was placed in a newsletter format and contained outcomes, actions, quotes from the groups and plans for future groups. The newsletter was sent to all allied-health professionals within the health organisation, and served as a communication about the progress and content of the group processes and an opportunity for allied-health professionals across the health organisation to give feedback about the content.

*Step 7 – Cross-checking with participants and colleagues*

Constant cross-checking with group participants throughout the action-research process ensured that the policy text reflected the meaning of their discussions and decisions. Checking also occurred through the distribution of the outcomes in regular newsletters, which invited
comments and participation regarding the interpreted meaning and texts. This invitation was included in the content of the newsletter, which was emailed to all discipline heads for distribution to allied-health professionals with a request in the email to encourage newsletter recipients to comment on the content. This enabled at least 4 x 3 group opportunities and five newsletters on which other allied-health professionals could comment.

Step 8 – Repeating process for next group

Steps 1-7 were repeated for each group for the total of five cycles. Following the final session and newsletter, the policy was circulated as a text in draft to allow further checking amongst the wider allied-health group. An example of feedback received is located in Portfolio 2.3.6.

2.10 Synthesis of All Texts Within the Study

I immersed myself in a meta-interpretation of the synthesised texts, using a concentrated hermeneutic process of fusion of horizons. I completed a synthesis of all texts generated from the study, including my pre-understanding and emerging understanding. The meta-interpretation ensured that all possible horizons and understanding from the texts had been explored. The resulting products were a set of clinical-supervision tools.

Meta-interpretations or syntheses are consistent with an interpretive paradigm, and are more often discussed in the context of reviewing or interpreting qualitative literature (Schlomann & Schmitke, 2007; Stevens, 2007; Walsh & Downe, 2005; Weed, 2006; Zimmer, 2006). Meta-interpretation refers to achieving an overall view or broad sense of the meaning (Walsh & Downe, 2005). Walsh and Downe (2005, p. 70) describe this as getting “the big picture”, which I achieved in this study by deeply questioning all text sets and all interpretations. These interpretations included pre-understandings and Level 1 and 2 interpretations. The process of meta-interpretation explored the experience of clinical supervision in allied health within the hermeneutic
elements of the hermeneutic circle, fusion of horizons, and dialogue with and questioning of texts.

Multiple sources for texts presented a further opportunity on which to draw understanding about the experience of clinical supervision in allied health. Each interpretation added a layer of reflection and meaning, which increased the richness of available text and the depth of interpretation, qualities van Manen (1997) states are important to capturing the breadth of an experience’s meaning.

2.10.1 Text-construction strategies – synthesising all texts to construct a clinical-supervision model.

One of the aims of this study was to provide a foundation on which to base supervision and policy development focused on health professionals. After finding few allied-health clinical supervision models, I decided that a model would be able to provide a structured foundation and facilitate a practical use of the meta-interpretation.

Texts used in this phase included the literature text set, the experiential text set such as texts resulting from the survey, the action-research process, my notes from observations and interpretations, a reflective diary, policy documents, newsletters and audio recordings. Further texts were also constructed throughout the meta-interpretation process and were progressively included in the interpretation of new understanding. These included pictorial representations of participants’ responses (Portfolio 2.2.6 & 2.2.7), conference posters and presentations (Portfolio 2.4), thematic mapping (Portfolio 2.2) and exemplar narratives (Portfolio 2.2.5). I use the term “synthesis of text” in Figure 1. Research Design, to refer to the overarching process within the research design and subsequently use the term meta-interpretation to describe the method of interpretation used to generate texts.
2.10.2 Meta-interpretation of all texts to find a foundation for practice

Engaging in a hermeneutic meta-interpretation facilitated an understanding that acknowledged my pre-understanding, ideas, categories and theories that I brought to the interpretation, thus enabling a new understanding or horizon to emerge from the text. I was able to access the knowledge of the broader study, which included survey results and the texts available from the action-research groups. This knowledge formed part of the deeper interpretation of text and was an important part of understanding the meaning of the whole, a process acknowledged by Guba and Lincoln (1989).

Questioning the text is an important hermeneutic element that was useful in the meta-analysis. Taking myself and the text to a further understanding required my remaining open to the questions from and to the texts (Bleicher, 1980). To achieve this I engaged with the text using variety of techniques, such as reading the text as a whole, noting broader and more detailed themes as they emerged and using pictorial representations of text.

Step 1 – Immersion in the text – listening and reading

This immersion required me to be attentive to new messages, to be aware of my old horizon, so as to be open to the new and emerging meanings. I therefore immersed myself in all texts through listening to recordings and reading the available texts and text sets repeatedly over a period of 10 months following the construction of the experiential text sets. This meant that I was able to return to the text again and again, looking back each time to the horizon before, building on the cumulative understanding without depending on it.

Step 2 – Making note of important, unexpected meaning and messages

Following Step 1, I underlined key words from each response and made handwritten notes in the margins of the text about my interpretation of the highlighted sections’ meaning, a method used by Elo and Kyngäs (2008). I
repeated the process in a similar way to those completed for the survey and action-research texts, to ensure that I approached the text with the same fresh eyes I had used when seeing the text for the first time. During this step I needed to uphold a reflective position to remain open to the messages emerging from the text, rather than imposing any predetermined idea of my own.

**Step 3 – Collating main messages for each experience and applying categories or labels**

Following Step 2, I reviewed the text for words or phrases that had similar meaning or represented similar concepts. These ideas were collated into lists and tables (Portfolio 2.2). In selecting the categories or labels, I drew on my pre-understanding from the study to adequately reflect the emerging meaning, drawing from the stories and experiences I had read and heard from participants.

**Step 4 – Grouping like categories into themes**

Themes are a way to simplify the understanding of the phenomenon and give structure to experience (van Manen, 1997). In the meta-interpretation this meant looking back to make connections to all aspects of the study, then forward to making new connections in meaning. With this heightened awareness I examined the categories and labels for common concepts or experiences. This step enabled a higher level of abstraction. My initial theme-allocation attempts resulted in numerous narrow themes that would lead to an understanding of most experiences; however, some experiences remained unaccounted for in the explanation. This indicated that I needed to return to the text to create a deeper, more inclusive understanding. This process of moving from the “part” of single words to the “whole” of sentences and from narrow themes to broader understandings and back again, formed the hermeneutic circle (J. Smith, 2007). As themes emerged, they were compared with each of the experiences to ensure that there was a complete understanding of all experiences. When the emerging themes were able to account for all
experiences and no new themes were emerging, I considered the themes to be saturated.

**Step 5 – A dialogue of question and answer**

The hermeneutic element of dialogue with the text encourages questions to and from the texts. Questions I asked of the text during analysis included: What is the overall experience of supervision: is it positive or negative? What is the participant doing/feeling? What is the main message the participant is trying to convey? When identified categories did not fit with the main themes or were applicable across more than one theme, I completed further analysis of each story to describe the essence or core message from each description. For example, frequency of clinical supervision was a common issue that arose from participants. However, as a theme, frequency only partly described the broader theme of access when I applied it to a range of clinical-supervision experiences. Access as a theme was able to explain several other issues such as geography, part-time workers and clinical workload. Themes were established and re-established in an attempt to encompass all of the issues the participants identified.

**Step 6 – Revising themes in response to checking against individual responses**

To ensure that I remained open to new essences of meaning within each text, I drew each response from the survey as a picture to ask myself what was its core meaning (example Portfolio 2.2.6 & 2.2.7). Thus I engaged in a new and significant way with each text, allowing time for new questions to emerge as I checked each picture and my understanding of the meaning against each theme. I sought any occurrence where the theme could not explain the meaning, and made adjustments to the themes accordingly.

**Step 7 – Developing a clinical supervision model for allied health through questioning overarching categories for order and effect**
I began to question the text about how the themes I had identified represented an allied-health clinical-supervision experience, and whether the themes provided a process for achieving the described ideal of clinical supervision. I undertook further interpretation of the text to place the themes parallel to each other in a structure that would be easily understood and would reflect allied-health professionals’ experiences of clinical supervision. I positioned themes in a number of combinations and orders until they functioned as larger domains across the experiences and their order imposed an overarching structure. The structure gave visual representation to the relationships of the themes with each other and with the ideal of clinical supervision. In each iteration of the themes, I asked: if they were not in the current place, could clinical supervision take place? I situated the identified themes around each other, which presented them visually and theoretically as parts to a clinical-supervision whole. I found that the ideal placement of these themes occurred when the structure placed the supervisee needs at the centre (Chapter 7). This was when a clinical-supervision model emerged by creating an inclusive explanation of the clinical-supervision needs in allied health. Thus the Allied Health Key Dimensions Model was formed (Chapter 7).

2.10.3 Further synthesis of all texts to construct a clinical-supervision conceptual framework – a clinical-supervision toolkit

I considered synthesis in this study to be the combining of separate elements into a meaningful whole. The final text-generation strategy in this study was a further meta-interpretation based on all previous knowledge and texts. This was again consistent with the hermeneutic circle in understanding the meaning of the texts and experiences in the context of each part of the study.

I immersed myself again in the many parts of the texts and interpretations, and was in want of an overarching explanation of the outcomes of the study, to make them accessible and applicable to everyday clinical supervision practice in allied health. The outcomes of the study to that
point had been based on the action-research process, the clinical-
supervision policy and the clinical-supervision model as tangible
responses to the aims of the study. I asked of the text, was there more to
tell? As a result of this questioning, I identified that the text required a
further interpretation to understand the research outcomes as a tangible
whole, which could translate the knowledge of the study into practice. I
continued to question the text.

I decided that a visual repository for the outcomes of the study could
optimise their accessibility to allied-health professionals. I thus developed
a conceptual framework as the best representation of the outcomes of the
study. This provided an outline of each key element needed to achieve the
ideal supervision as set out by the participants in my study.

The process of meta-interpretation used to develop this conceptual
framework was, first, to immerse myself in each of the texts to understand
what participants would require from a framework. Understanding the
participants’ experiences deeply at this point in the study was important;
however, I needed to remain open to any new possible meanings. The
concept that the outcomes of the study could be used as clinical-
supervision tools was also a significant factor in naming the framework as
a toolkit; that is, something in which tools are kept. I immersed myself in
the outcomes of the study to understand any interaction between them,
and ensured that these were reflected in the toolkit. I placed the outcomes
of the research adjacent to each other within the toolkit. This presented
the tools and their use, along with the experiences they had come from, in
a visually accessible form.

The question I then asked of myself and the text was: was there more to
tell? I asked a question of the text. How can the outcomes of the study be
used to achieve an ideal of clinical supervision in allied health? In this
second meta-synthesis, I relied heavily on the hermeneutic tools of
questioning to and from the text. I read through the texts once again
asking the text what the key elements of the study were. Four key
elements emerged strongly from the texts: reflection, people, practice and
structure. Whilst I felt a strong need to question these themes, I understood these four elements to be answers, and therefore waited for the questions to emerge. Five questions emerged. What was needed? What happened in the groups? What was important? What changed? Who was important? I asked all five questions of each element and also remained open to any other answers to these questions.

Following this last step in the meta-interpretation, I reviewed all texts again, to search for any further questions or meanings of which I had not been aware. No further meanings emerged for me, and I was satisfied that with appropriate checking with colleagues and supervisors, all interpretation of the texts had been satisfactorily undertaken.

In this section I have given an overview of each text set and the text-generation strategies used within each. In the following section I will discuss the strategies employed to ensure the ethical and high-quality conduct of the study.

2.11 Quality of the Research Cycle

It was essential that the quality of the research cycle was maintained throughout the research process. Rigour in qualitative research ensures that the findings are trustworthy (Given, 2008). When research is trustworthy the reader knows that the findings are important and have been carried out with credibility (Lincoln & Guba, 1985). Credibility, auditability, fittingness and transferability are four quality-measurement processes that are appropriate for qualitative research (Creswell, 2013; Minichiello, 1999). Addressing issues of the credibility, auditability, fittingness and transferability of the study was essential to ensure the quality of evidence (Creswell, 2013; Lincoln & Guba, 1985; LoBiondo-Wood & Haber, 2006).

Credibility is the means by which trustworthiness is enacted; it requires the participants to identify with the text interpretation as representing their views, and for others to believe the presented interpretation (Given, 2008;
Lincoln & Guba, 1985). Given (2008) suggests five ways to enhance credibility. I applied them in five ways:

1. Time – Adequate time should be spent with participants to achieve a depth of understanding. I ensured this by spending time immersed in and reflecting on texts and spending extensive time with participants in the action-research group process. Prolonged engagement with participants and texts is suggested by Lincoln and Guba (1985). In this study I achieved prolonged engagement through intensive interaction with the participants and progressive texts over a three- to four-month period, and engaging with the whole texts again over the course of two years. As a result of repeated engagement with participants and texts, I created a space for all voices and versions of an experience to emerge. This space also enabled me to be alert to any understandings that might be inconsistent with the participants’.

2. Angles – A range of perspectives and viewpoints should be encouraged. I presented multiple opportunities for participant engagement in this study, such as the anonymous survey, action-research groups and opportunities to give feedback on newsletter summaries and the developed clinical-supervision policy. This made available a range of experiences and viewpoints, as well as ensuring that participants were comfortable voicing honest opinions and feedback. This range of options to participate increased the likelihood that participants gave open and honest responses, which increased not only the range of viewpoints captured but the types of viewpoints within the study.

3. Colleagues – Available networks should be used to critique and review research. I was able to access professional colleagues to review my progressive interpretation of constructed texts. These colleagues provided challenges to my assumptions and prejudices and prompted me to remain open to the messages from the texts. I regularly checked with my doctoral supervisors, who checked for thematic gaps and provided critical feedback on my thinking, interpretation and emerging
understanding. Guba and Guba (1985) describe this process as peer debriefing, and state that it provides the advantage of exploring aspects of the research that might otherwise remain unchallenged.

4. Triangulation – Multiple sources of information, participants and techniques should be used to ensure that more than one understanding of an experience is available for interpretation (Lincoln & Guba, 1985). I used multiple text sets and text-construction strategies to access a range of experiences from a wide range of participants experiencing clinical supervision in allied health. This is demonstrated in the research design (Figure 2).

5. Member checking – Confirming the findings and interpretations with participants is essential to the credibility of the study. Checking understanding and findings with participants allows opportunity for them to review the researcher’s interpretation of their own reality (Lincoln & Guba 1985). Given (2008) suggests three levels of checking. In this study these levels also correspond to the three levels of hermeneutic interpretation.

First, participants were asked to evaluate descriptive elements to ensure that the researcher had appropriately described their experience. In this study I gave participants this opportunity at every action-research group, and, more widely, invited all allied-health professionals in the health organisation to respond to the newsletter content. The action-research groups confirmed the accuracy of the survey text through their strong identification with the survey participants’ written stories. I made the clinical-supervision policy available for wider comment before submitting the document for formal approval to all allied-health professionals. This process was aimed at confirming the policy text as a credible representation of the clinical-supervision needs in allied health and increasing support during future policy implementation. The newsletters, which were released following each group session, gave an opportunity for the wider allied-health population to confirm that results and progress represented their experiences.
Second, I asked participants to evaluate what had been interpreted, to ensure that I had captured the meaning of the experience. I asked participants to comment upon and clarify my interpretations following the survey interpretation and following each action-research cycle. This ensured that the participants played an active role in shaping and refining the findings.

Third, I performed a final theoretical check to confirm that the outcomes and findings were an accurate portrayal of the experience. In this study, this final check of the outcomes of the meta-interpretation was achieved through the feedback of colleagues and supervisors, and my deep connection with the text and the participants throughout the study. This retrospective consideration after the primary text construction is an acceptable final check for representativeness (Given 2008).

Auditability requires demonstration of a transparent and easy-to-follow process leading from the research question to text construction, and interpretation (LoBiondo-Wood & Haber, 2006). I shared with participants, explicit examples of texts and my interpretation of them in written and visual forms, such as graphs, charts and verbal explanations. I used a visual representation to openly convey the text-interpretation processes, allowing opportunity to receive feedback on preliminary findings from the group and the wider allied-health population. Audit trails from the survey-text interpretation illustrated the movement from text to themes, and ensured that the findings and conclusions were supported by the text (Creswell, 2013). Examples of these include my emerging ideas, hunches and concepts. Texts constructed throughout my interpretation were recorded and stored, as was the audio recording of the group process. Examples of these processes are included throughout the exegesis as an illustration of an adequate audit trail throughout the study.

Fittingness examines applicability and transferability of findings outside the study conditions and whether analysis strategies are compatible with the study purpose (LoBiondo-Wood & Haber, 2006). Transferability in qualitative research refers to a study’s ability to identify common patterns
in the phenomena being examined, rather than making general claims about large groups of participants (Owen, 2008). This has implications for the applicability of a study’s findings in different contexts and situations (Jensen, 2008). Transferability is achieved through the researcher building a detailed or thick description of the method, participants and context of the study. This enables the reader to determine for themselves whether the findings would or could apply in their own context or situation (Creswell, 2013; Jensen, 2008; Joseph & Mittapal, 2008). In this study the reader can decide whether the study results transfer to other settings by referring to the detailed description of the study context, within a specific health organisation and geographical location and with a specific group of participants (Creswell, 2013; Lincoln & Guba, 1985).

Three further assurances of research rigour were engaged to ensure credibility and confidence in the research outcomes: thematic saturation, reflexivity and hermeneutic writing (Ajjawi & Higgs, 2007; Creswell, 2013; J. Smith, 2007; van Manen, 1997)

Thematic saturation occurs when no new themes emerge and there are no unexplained occurrences in the text. The emergence of themes from the texts are questioned until the new horizon confirms the final invariant themes (Crotty, 1996). In this study I achieved this when I identified the themes emerging across the complete survey text, and confirmed a strong consistency of ideas with minimal variability and where all text fitted well into the identified themes. This suggested that no further interpretation was required to understand the experience of clinical supervision in allied health.

Reflexivity is the recognition of the specific ways a researcher influences the study (J. Smith, 2007). Hermeneutics as a methodology overtly recognises the role of the researcher in interpretation, and gives detailed accounts of how this develops. I became part of the text-construction process and used a reflexive approach to recognise and acknowledge my influence when collecting, generating and interpreting texts. Reflexivity required me to reflect on my own values, beliefs and research
expectations, and how they affected my text construction, interpretation and findings, as discussed by (Gough, 2003; Maso, 2003). It was essential as a researcher that I attempt to relinquish authority and expertise and reflect upon investment in any particular research outcome (Finlay, 2003). It is feasible to expect that as a senior manager within the health organisation, my values and beliefs would be influenced by organisational expectations. This was counterbalanced through diarised self-reflection sessions following each text construction and each action-research session, as suggested by Lincoln and Guba (1985). Reflecting was an attempt to revisit thoughts and feelings within the groups, to relate this to prior knowledge and values as a manager and to challenge these when required. In this study I was the principal researcher. I have a professional background in speech pathology, working within the health district being studied, with an interest in clinical supervision; this was made clear to all participants. I was also a doctoral student and head of the allied-health department, working within the participating health service, and was acting as both facilitator and researcher within the groups. I regularly and explicitly acknowledged my leadership role within the health organisation throughout the study by commenting about the way in which it might affect participant’s openness.

Hermeneutic writing is a key dimension of the hermeneutic method. Text as language in all its forms is the focus of the research process (van Manen 1997). Therefore writing was a key part of demonstrating the quality of this hermeneutic study, through both the physicality of the record and the demonstrated pathway of changing horizons. I used writing as a path to illustrate reflexivity in this study through writing regular reflections and as evidence of my thoughtfulness about texts. Van Manen (1997) suggests that whilst reflective writing brings a physical distance from participants, the act of writing is a conscious reflection of changing layers of meaning within the text. The hermeneutic circle requires a constant movement back and forth; each act of writing was a tool to achieve this, and in each movement came depth of understanding. Through writing, I was able to make the concrete abstract and bring the abstract into the
concrete. This was demonstrated through dialogue with text, documenting the question that the text asked and those questions I asked of the text, a technique valued by van Manen (1997).

2.12 Ethical Issues

Clarity around ethical issues was achieved through the production of a code of ethics given to each participant, with details about information collected, what I intended to do with the information and my plan for treating the participants and their information with confidentiality (Portfolio 1.1.6).

Approval from the Charles Sturt University Minimal Risk Committee and the University of Wollongong Health Service Human Research and Ethics Council was obtained, with changes made as appropriate (Portfolio 1.1). The minimal-risk pathway was seen to be most appropriate due to the low level of risk identified through the minimal-risk checklist (Charles Sturt University, 2016).

Participants were given a written code of ethics informing them that participation was voluntary and that they were able to terminate the action-research cycle at any time without penalty or reprisal. A complete description of the study that complied with ethical requirements was included as an introductory letter preceding the consent form (Portfolio 1.1.7). It was also recognised and stated that a timely report of results was required for distribution to participants. This was achieved by distributing a copy of the policy within one month of completing the action-research groups. Written consent was sought from each participant prior to commencement of the cycle. Consent forms are currently stored securely and after seven years they will be destroyed as per Health Service requirements.

To mitigate such risks several strategies were employed:

1. A monitoring process was put in place to ensure that any risk was identified quickly. This process consisted of observation from the
researcher and a reminder at the end of each cycle about how participants might wish to respond to feelings of distress or discomfort (NHMRC, 2007).

2. An adequately trained and experienced researcher was used to ensure a sensitive approach to all topics and questions (NHMRC, 2007).

3. Protocols for managing distress included offering Health Service counselling services; these counsellors were qualified to manage distress most appropriately. Contact details were provided upon consent.

4. Possible risks were clearly identified in the consent process.

5. Declining or withdrawing consent requires that participants who do not elect to participate in, or decide to withdraw from the research, suffer no adverse consequences or disadvantages as a result of their decision (NHMRC, 2007). This was made clear to all participants through the consent process and was clearly stated on the consent and information forms (Portfolio 1.1.6). This was particularly important for the health professionals who were working in the allied-health department led by the researcher at the time of the study.

2.13 Care and Management of Texts and Information

Non-identifiable information was used in the survey and profession-specific detail was not requested to ensure information was not identifiable. Identifiable information was used within the action-research groups. Names, professions, place of work or supervision experience were neither requested nor required in the action-research groups; however, the participants’ professions were often made clear from their reflective stories, and it was socially acceptable for them to introduce themselves and their names following my introduction of myself. Action-research participants are identified in this exegesis only by the groups in which they participated; they cannot be identified individually from this information. Any reference to their gender has also been removed to further de-identify participant quotes. Survey participants were allocated a
number by the survey tool (for example, “participant 50”); this number is used throughout the exegesis as an anonymous reference point.

Consent sheets were stored within a secure location with access by the researcher and research assistant only. Specifically, texts and information were stored in two locked filing cabinets at the hospital where I was working. Texts and information required transport from the research location to the text-interpretation locations. During transportation, the texts and information were placed inside a zippered and locked briefcase and were never left unattended. Interpretation occurred at my hospital site or my home. Written texts and information were secured in a locked filing cabinet at each location when not in use. Transport occurred from action-research group sites to the two text-interpretation locations only. Audio recordings of action-research groups and typed reflections and interpretations were stored on a portable hard drive and secured with the written texts as previously described.

2.14 Complaints

The complaint-management procedure was clearly outlined to participants throughout the research process (Portfolio 1.1.6). The procedure provided two contact points, one within the health organisation and one within the university. This ensured that participants who did not feel comfortable contacting a person within the health organisation had an alternative contact outside the organisation.

While no complaints were received, plans were in place to clearly follow the complaint-handling procedures within each institution, as well as those recommended by the NHMRC (2007). The process for making a complaint was clearly stated in the consent procedure.

2.15 Chapter Summary

This study used qualitative research methods to develop an understanding of clinical supervision in allied health and aimed to apply this understanding by producing a policy, tools and frameworks for practical
application. An overarching interpretive paradigm and hermeneutic methodology was informed by several strategies for the construction of texts. The methodology of hermeneutics and the key role of the action-research process supported an interpretive process of discovery through the inclusion of context within the research activity.

The study had three text types and five strategies for text generation. The results of the first text generation – a review of available literature – was used to form my pre-understanding, and became a published literature review. The second text was constructed from an anonymous survey and action-research groups, which generated rich experiential text sources. All texts and results from texts 1 and 2 were instrumental in text synthesis for text 3, a hermeneutic meta-interpretation. The study and texts were thus iterative and built an understanding of clinical supervision in allied health using a range of texts as a foundation for new and shared horizons.

The chapters that follow present the research texts in a number of ways. Chapters 3, 5 and 7 are presented in the form of published or submitted peer-reviewed journal articles. Chapter 6 is a descriptive presentation of the clinical-supervision policy. The survey text is attached in Appendix 1 in the form that was presented to the action-research groups for their interpretation. I present a range of texts in my exegesis; this has allowed me to step back from the real-life practice of clinical supervision, and provided a space to reflect on this practice and a means for practical application of the study outcomes.
CHAPTER 3: LITERATURE TEXT SET

3.1 Introduction

This chapter begins by providing an awareness of my pre-understanding of clinical supervision in allied health. As detailed in Chapter 2, this text represents my pre-understanding from beginning the research journey to commencing the generation of experiential texts. Chapter 3 uses a peer-reviewed, published literature review to explain the importance of, and need to further understand, clinical supervision for allied-health professionals. It also demonstrates the relevance of the information presented to the wider health audience.

To engage in a complete discussion about clinical supervision in allied health, it was important to understand the available literature. The literature review was published in 2012 and was the product of the literature available at the time. The search for allied-health-specific literature revealed a gap; since 2012 studies have gradually emerged to fill this gap. This signifies an increasing recognition of the role clinical supervision plays for both health professionals and organisations. Thus literature emerging from 2012 to 31 March 2016 became part of my ongoing and expanding horizons, as shown throughout this exegesis. This is consistent with the philosophy of shifting horizons in a hermeneutic study, where my understanding and horizons would continue to develop throughout the whole study, culminating in my exegesis as a final text creation.

3.2 Published Findings

The publication that summarises the literature review, provided below, was accepted for publication on 26 April 2012 to the Australian Health Review. It was published online in November 2012, and is presented in the format required for that journal. The contributions of the co-authors for all published papers is outlined on pages 6-7 of this exegesis.

Quality allied health clinical supervision policy in Australia: a literature review

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Abstract. Clinical supervision is presented as a complex set of skills that may broadly apply to any and all allied health professions. However, it is also noted that a clear understanding of clinical supervision and how to implement it in allied health is currently lacking. It is argued that there is a need to reflect upon current approaches to clinical supervision amongst allied health professionals and to gain a shared understanding about what supervision involves, what effective supervision is, and what effective implementation of clinical supervision might look like. By gaining an understanding of what high quality clinical supervision is and how it is best put into practice, it is anticipated that this will form the first step in developing an understandable and useful universal supervision policy for all allied health professionals.

What is known about the topic? Clinical supervision is important because it improves quality of care for clients and it may also improve staff satisfaction and retention rates and clinical governance for organisations. There is a clear need for a well-articulated supervision policy in allied health as there is currently no comprehensive and universally accepted supervision policy for this group of health professionals.

What does this paper add? This literature review argues that if there is no clear supervision policy that is endorsed at a whole of health level there is a risk that disparate, haphazard, and poorly coordinated approaches to supervision may result in poor quality of supervision provision. Much of the recent literature is profession-specific; however, this paper contends that there are many possible reasons for collaboration in establishing clinical supervision in allied health. The possible barriers to implementing a universal policy are also examined.

What are the implications for practitioners? This literature review will help practitioners understand the complex issues that inform the clinical supervision process and particularly those factors that affect the delivery of an excellent quality of supervision. This knowledge will help them to assess the quality of supervision they receive and provide, and may also contribute to motivation to work with colleagues to develop meaningful supervision skill.

Received 4 June 2011, accepted 26 April 2012, published online 2 November 2012

Introduction

This paper presents a review of literature that discusses clinical supervision in health-service practice. The databases of the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, PsychINFO and Medline were searched from 1920 to 2010 inclusive. The keywords used were: supervision, clinical supervision, professional supervision, health, and allied health. An internet search using Google and searches of the Joanna Briggs Institute and the Cochrane Library were also conducted with these same search parameters. Members of Speech Pathology Australia, Occupational Therapy Australia and the Australian Physiotherapy Association also sourced relevant documents from these professional associations. These searches identified several hundred papers. The list of publications was reduced to 25 by selecting those that were most relevant to allied health and those that most directly discussed the aims and definition of clinical supervision and its effectiveness and supervision policy.

Ensuring the provision of quality supervision for allied health professions requires understanding of and agreement about what constitutes effective supervision and how it might be achieved.1-9 The provision of high quality supervision has been associated with good patient outcomes10 as well as improved staff wellbeing and satisfaction.1 High quality supervision also supports staff and maintains staff competence as well as making available best practice service for consumers.4,11,12 Thus, providing excellent supervision enables health organisations to comply with many of their governance and safety requirements.4
Many states of Australia already have policies that target the provision of clinical supervision. In 2009, South Australia produced the Allied Health Clinical Support Framework and Western Australia generated the Foundations to Supervision. These documents detailed frameworks for how to provide clinical supervision. Queensland Health also has plans to implement a professional support framework, inclusive of policy and guidelines, professional support guides and training packages, and programs. More recently New South Wales Health Clinical Education and Training Institute released a general guide for clinical supervision in allied health titled, The SuperGuide - a handbook for supervising allied health professionals. This handbook’s approach to clinical supervision includes broad principles for supervision which are aimed at inexperienced clinicians; however, there is also recognition that ongoing professional development for all practitioners is required for registration requirements and the provision of a high quality health service. Thus, at a state government level, there is a clear commitment to developing clinical supervision in allied health. There is also a possibility that the principles of supervision may be broadly applicable across states and professions.

A diverse, yet single, entity
The definition of allied health varies from state to state; however, the most effective way of defining this group might be by detailing which professions are excluded rather than listing all those that may be included. In 2001, Boyce identified that allied health professions were those that were bonded through being separated from medicine and nursing; this division is widely recognised.

Groups that are incorporated as allied health may often be determined at the discretion of the employing organisation. New South Wales Health lists a very broad range of professions under the banner of allied health. South Australia Health described allied health professionals as ‘Tertiary qualified health professionals who apply their skills to restore optimal physical, sensory, psychological, cognitive and social function. They are aligned to each other and their clients’ (p. 3). This is also the definition adopted by the New South Wales Institute of Rural Clinical Services and Teaching.

Even though many professions may be classified under the umbrella term of allied health, this does not necessarily mean that each profession needs its own profession-specific supervision policy and practice. Some authors assert that the skills and process of clinical supervision may apply to all health professionals, including all those listed as ‘allied health’. Indeed, collaboration between professions may expedite the development of effective supervision policies and procedures.

**Impediments to effective supervision**

**Absence of an agreed aim and definition of supervision**

Currently, there is no single universally consensual definition of supervision within allied health. It may not be possible to find an agreed ‘perfect’ definition for supervision; however, some agreement on definition would appear to be important. Van Osjen proposed that agreement on definition may provide a clear understanding of the nature and purpose of supervision, and should be the starting point when developing guidelines for supervision. Similarly, Driscoll suggested that clarifying the ‘what’ and ‘why’ of supervision would capture the complexities of supervision in healthcare practice.

In order to have a useful definition, there may need to be agreement on a definition within the context in which the term, supervision, is being used. For example, defining the context may facilitate clarification of the aims of supervision. Table 1 illustrates an array of perspectives of supervision, as well as outlining possible functions of supervision.

These definitions reflect that authors have variously focussed on: the protective function of supervision when aiming to ensure quality care for clients; the supportive developmental process when contributing to the personal growth of the supervisee; or, the function of education when concentrating on the supervisee’s professional growth of knowledge and skills. Therefore, a unifying framework for understanding clinical supervision may be one that encapsulates the three notions of protective, and personal and professional developmental functions. The following definition is therefore proposed. Supervision is any activity where more experienced health professionals provide less experienced health professionals with opportunities that enable these health professionals to achieve learning, to receive support, and to improve the quality and safety of their practice.

**Absence of agreement about how to recognise effective supervision**

Characteristics that are proposed as contributing to the provision of effective supervision are summarised in Table 2. As shown in this Table there are a large number of supervisor qualities that are highlighted as being necessary for effective supervision, and while there is some overlap between authors, there appears to be lack of general agreement about which are the essential requirements.

**Absence of good training in clinical supervision**

There appears to be lack of agreement about what are the core competencies of supervisors and what type of training, and how much, is required for supervisors. It seems that there is not

<table>
<thead>
<tr>
<th>Table 1. Definitions and functions of supervision - examples</th>
</tr>
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<tbody>
<tr>
<td><strong>Definition</strong></td>
</tr>
<tr>
<td>Supervision is a protective process that ensures effective provision of health care</td>
</tr>
<tr>
<td>Supervision provides ‘monitoring, guidance, and feedback’ in the care of patients</td>
</tr>
<tr>
<td>Supervision enables reflection on one’s own views and beliefs</td>
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<tr>
<td>Learning is at the core of supervision</td>
</tr>
<tr>
<td>Supervision is about protecting the client</td>
</tr>
<tr>
<td>Supervision is about reflecting on clinical practice</td>
</tr>
<tr>
<td><strong>Author</strong></td>
</tr>
<tr>
<td>Jones</td>
</tr>
<tr>
<td>Kilminster &amp; Jolly</td>
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<td>Van Osjen</td>
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<tr>
<td>Carroll</td>
</tr>
<tr>
<td>Hawkins &amp; Shabot</td>
</tr>
<tr>
<td>Driscoll, Rice</td>
</tr>
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</table>
Table 2. Characteristics of effective supervision

<table>
<thead>
<tr>
<th>Description</th>
<th>Author</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability, knowlegability, supportiveness</td>
<td>Allen²</td>
<td>1986</td>
</tr>
<tr>
<td>Instructiveness, modelling, provision of feedback, monitoring of practice</td>
<td>O'Kone³</td>
<td>2000</td>
</tr>
<tr>
<td>Flexibility, openness, sensitivity, humour, humility, patience</td>
<td>Hawkins &amp; Shohet²</td>
<td>2000</td>
</tr>
<tr>
<td>Protection of time for supervision, adequate staffing</td>
<td>Connell²</td>
<td>2002</td>
</tr>
<tr>
<td>Accessibility, flexibility, responsiveness</td>
<td>Strong²</td>
<td>2003</td>
</tr>
<tr>
<td>Proficiency in interpersonal interactions</td>
<td>Winstanly³</td>
<td>2003</td>
</tr>
<tr>
<td>Provision of directive guidance, meeting the needs of the supervisee, positive collaboration</td>
<td>Overhulse²</td>
<td>2004</td>
</tr>
<tr>
<td>Availability, knowlegability, supportiveness, professional role model, a mutual and interactive style of communication, similarity of clinical perspectives, encouraging professional growth</td>
<td>Bugo⁶</td>
<td>2005</td>
</tr>
</tbody>
</table>

...even agreement that training ought to be compulsory. However, many authors² have asserted that appropriate, specific and high quality training of clinical supervisors is vital. Despite such calls for education for supervisors, many supervisors may assume supervisory roles with little specific preparation and instruction about supervision.³⁴

Absence of clear mechanisms for implementing clinical supervision

Several authors have described the need to have adequate policies, guidelines, or systems¹ in order to clearly direct organisations and their employees in the performance and management of clinical supervision. Barratt’s audit of supervision in a primary care setting in the United Kingdom led her to assert that each organisation should provide guidelines for the arrangements of clinical supervision. Other authors³⁴ have emphasised that clear articulation of clinical supervision policies, including mechanisms to resolve problems that occur within clinical supervision, are necessary. However, despite the clear need for guidance about how to implement supervision, no policies that discussed means of implementation were identified.

Enablers of effective supervision

A unified supervision model

In 1986, Proctor² proposed a model to represent supervision that emphasised the functions or purposes of supervision: the Interactive Framework of Clinical Supervision. The key features of Proctor’s model included functions of learning, support, and accountability. The concept of learning was the development of skills and abilities through reflection on one’s work.²⁸ Support was about managing and recognising the emotional responses occurring within the healthcare environment, with an aim to renew the spiritual strength of the supervisee.²⁸ Accountability was concerned with effectiveness, safety, and the prescribing of standards and how these are addressed within the process of supervision.²⁸

A key component to Proctor’s model was the interaction between each of the three key elements.

In 2007, Driscoll²⁵ reconsidered Proctor’s² model and proposed that the most meaningful aspect of the model was that the three functions overlapped; all three purposes were objectives of clinical supervision. Driscoll²⁵ revised model might be considered as an appropriate framework for clinical supervision for allied health. For example, the simplicity of the model ensures that it may be easy to use as well as easy to remember. In addition, the model allows for the accountability requirements of the organisation and also for the support and learning requirements of the supervisee.²⁶,²⁷,²⁸

A unified supervision policy

Several authors²⁵,²⁶,²⁷,²⁸ have advocated the need for clear guidelines and policy for the implementation of clinical supervision. Many professions have national requirements for clinical supervision, such as pharmacy, physiotherapy, podiatry, psychology and optometry.³⁹ In addition, some professional bodies are considering what their profession-based understanding of clinical supervision is. For example, Speech Pathology Australia has developed The Role and Value of Professional Support,²⁸ Occupational Therapy Australia has published Supervision Guidelines²⁶,²⁸ and the Physiotherapy Board of Australia²⁸ has produced Supervision for Limited, Provisional and Conditional Registration Guidelines.

There has also been profession-specific research about supervision undertaken by several authors. For example, in psychology, James²⁸ examined the micro skills used by supervisors and the use of scaffolding to facilitate supervision. In social work, Kaiser and Kuchler²³ described the efficiency of a training program for supervisors. In occupational therapy, Sweeney, Webley and Treacher²⁸ investigated the processes underlying supervision in occupational therapy. Interestingly, each of these examples discusses characteristics of clinical supervision that are in common with other allied health, such as supervisor skills and training, guidelines to direct the process and competence.

Although there may be some supervision issues that are profession- or organisation-specific, there are also clearly many others that are similar across different professions and different organisations. Given that supervision is an essential process for all allied health professions and for all health service organisations it would seem that an efficient and effective use of time and resources might be to develop an in-common policy of clinical supervision that could serve as the basis for all allied health professions in all states and territories of Australia.

Conclusion

This literature review has identified that although much has been written about the topic of clinical supervision in allied health practice there are a few key problems that impede the use of this information to improve the implementation of clinical supervision in allied health practice. These issues include the absence of:
an agreed definition of supervision; an agreed method for determining the quality of supervision; provision; an agreed method of preparation for providing supervision; and, a cohesive policy for the implementation of supervision. Thus, it is proposed that in order to improve the quality and efficacy of supervision provided for allied health professionals, there ought to be: an agreed aim and definition of supervision; a common understanding of what constitutes effective clinical supervision; high-quality training for clinical supervisors; and, clear implementation mechanisms and a unified model of clinical supervision. Given the importance of effective clinical supervision in providing high quality patient care and increasing staff satisfaction, it would appear timely and critical to move forward promptly with development of an appropriate allied health supervision policy as a matter of necessity.

References
10 Buari JO, Koot BG. Quality of clinical supervision as perceived by attending doctors in university and district teaching hospitals. Med Educ 2007; 41: 957–64. doi:10.1111/j.1365-2938.2007.02833.x


3.3 Addendum to Published Paper – Literature Update and Implications

The following literature has been released since 2012 on the topic of clinical supervision in allied health. The purpose of this section is to provide an update on the current understanding of clinical supervision in allied health, and for completeness in presenting recent literature in the field. Since 2012 the number of studies on clinical supervision specifically examining allied-health professionals as a collective has slowly increased. I located a small number of studies between 2012 and 2014 (Dawson et al., 2012; Dawson et al., 2013; Kuipers et al., 2013; Nancarrow et al., 2014; Pearce et al., 2013). From 2014 there has been a larger increase in the number of studies on the topic of clinical supervision in allied health (Ducat & Kumar, 2015; Ducat et al., 2016; Kumar et al., 2015; Leggat et al., 2015; Martin et al., 2015; Redpath et al., 2015; Saxby et al., 2015). This indicates an increasing interest in the role clinical supervision plays for both health professionals and organisations.

The role played by clinical supervision is a common topic in all these studies. Each refers to the role played by clinical supervision in allied health in both clinical governance and support for health professionals. The importance of clinical governance and accountability is often related to improving client outcomes or service quality (Leggat et al., 2015). Clinical supervision is also presented as a tool for improving the retention and wellbeing of health professionals through the provision of professional and personal support in the workplace (Moran et al., 2014; Nancarrow et al., 2014). The wellbeing and satisfaction of health professionals is of interest to health organisations because of the implications for workforce retention (Lynch & Happell, 2008a; O’Connell, Ockerby, Johnson, Smenda, & Bucknall, 2013).

Understanding what allied health needs for clinical supervision to be effective has been included as a topic in a number of more recent studies. These studies are retrospective evaluations of clinical supervision already in place, which is a valuable addition to the allied-health clinical-
supervision research landscape because there are limited number of studies examining allied health clinical supervision (Dawson et al., 2012; Dawson et al., 2013; Kuipers et al., 2013; Kumar et al., 2015; Leggat et al., 2015; Martin et al., 2015; Redpath et al., 2015; Saxby et al., 2015). Each of these studies discusses the ongoing lack of agreement about key requirements for effective allied-health clinical supervision; however, only Ducat (2016) attempts to shift from identified key elements to ideas about future implementation. Lacking is the involvement of allied health in the prospective design of their own clinical supervision.

Several studies focus on the role of clinical supervision in facilitating workforce retention (Ducat & Kumar, 2015; Ducat et al., 2016; Moran et al., 2014; Nancarrow et al., 2014; Saxby et al., 2015). Several of these studies have a narrower focus on the role clinical supervision plays in the overall support of health professionals in regional, rural and remote settings (Ducat & Kumar, 2015; Ducat et al., 2016; Moran et al., 2014; Nancarrow et al., 2014). Clinical supervision in these four studies is seen as one tool amongst many to assist in the support, and thus retention, of health professionals within these non-metropolitan health contexts, where retention is often problematic (Ducat et al., 2016; Moran et al., 2014).

Regardless of setting, two issues appeared consistently. First, the availability of time for clinical supervision has remained a problem for allied-health professionals accessing regular clinical supervision (Dawson et al., 2012; Dawson et al., 2013; Ducat et al., 2016; Kumar et al., 2015; Saxby et al., 2015). This means that a resolution for health professionals’ difficulties accessing clinical supervision has not been found even where a state-wide framework was in place (Kumar et al., 2015). Second, the importance of the supervisory relationship has been identified as having a positive impact on health professionals’ perception of the effectiveness of clinical supervision (Ducat et al., 2016; Leggat et al., 2015; Saxby et al., 2015). Health professionals’ input into their choice of clinical supervisor is suggested by Saxby as one way to improve the perceived effectiveness of clinical supervision.
The need for structure within clinical supervision remained a topic of concern. Requests for structure in the implementation and practical application of clinical supervision were a frequent recommendation or finding in more-recent research (Dawson et al., 2013; Ducat & Kumar, 2015; Kuipers et al., 2013; Kumar et al., 2015; Nancarrow et al., 2014; Saxby et al., 2015). Saxby (2015) found that clinical supervision was more effective when there was a clinical-supervision agreement in place. In 2014 Nancarrow et al. put forward a clinical-supervision model based on a thematic analysis of existing allied-health clinical-supervision frameworks. However, despite this, in 2015 Kumar et al. described a knowledge gap in the literature as a lack of a universal model for implementation of allied-health clinical supervision. This evidence from more-recent research confirms that clinical supervision is more effective when structures are in place to ensure agreement and consistency; however, knowledge about the types of structures and how to achieve them continue to be a gap in the field of clinical supervision in allied health.

One advancement in creating a unified structure for allied-health clinical supervision has been the proposal of two allied-health clinical-supervision models. Nancarrow et al. (2014) aimed to develop a supervision model for allied-health professionals working in a rural or remote context by performing a thematic analysis on existing allied-health clinical-supervision frameworks in rural or remote settings in Australia. The resulting model interpreted clinical supervision more broadly by incorporating it as one aspect of the support and education centred on the allied-health professional. Whilst Nancarrow et al. examined allied health as a collective, the analysis synthesised government policies, documents and clinical guidelines.

A model based upon reviewing current clinical supervision practice was developed by Ducat et al. (2016). Likewise, the context for this study was allied-health professionals in rural and remote settings. A positive clinical-supervision culture and supervisee-supervisor fit were found to be important facilitators of clinical supervision in allied health. Whilst both
studies have a rural and remote focus, the assumptions for clinical supervision in allied health outside this setting could benefit from these studies. These two models add to the knowledge about allied health clinical supervision; however, Nancarrow et al. attend to clinical supervision in the context of the overall support for the allied-health professional. This makes her study more broadly applicable to allied-health workplace support; however, its relevance depends on the ability of the frameworks used to establish the domains of the model. Ducat et al.’s (2016) model is narrow in focus, and therefore may not meet the need for a broadly applicable allied-health clinical-supervision structure.

Reviewing the literature has confirmed increasing interest in clinical supervision across all health professions. There is an appreciation for the potential benefits for clients, staff and health organisations. Several studies (Ducat & Kumar, 2015; Leggat et al., 2015; Martin et al., 2015; Nancarrow et al., 2014; Redpath et al., 2015; Saxby et al., 2015) have cited my literature review; this establishes a link between the relevance of the issues I identified to current emerging research. This study will address the identified gaps in understanding allied-health clinical supervision needs in relation to the need for an overarching structure which can facilitate implementation of clinical supervision in allied health.

3.4 Chapter Summary

The findings of my published literature review included a growing availability of literature on clinical supervision in health professions; however, specific research on allied health was lacking. The published review outlined the key messages from the literature. These messages concerned the need to be in agreement on what clinical supervision is understood to be, common goals, a method to determine quality of supervision and the need for overarching guidelines or policies to facilitate it.

Reviewing the literature across the period of my study has confirmed an increasing interest in clinical supervision across all health professions.
Researchers are moving away from simply understanding what clinical supervision means, to understanding what it looks like and how to make it work.

There is acknowledgement that the supervisory relationship is key to successful clinical supervision and, conversely, that making enough time available for clinical supervision continues to be problematic. A gap exists in the involvement of allied-health professionals in the development of their own clinical supervision alongside a broader need to understand how to make supervision sustainable.

The concept of implementation of clinical supervision is being explored with many approaches. It is clear that a structure is required that includes the support and investment of health organisations, managers and health professionals alike. This could address the identified gaps of understanding specific allied-health needs in clinical supervision, as well as the need for an overarching structure to facilitate success.
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CHAPTER 4: CO-CREATION OF AN ALLIED-HEALTH CLINICAL SUPERVISION POLICY: A PARTICIPATIVE APPROACH

4.1 Introduction

In this chapter, the first of three findings chapters, I present the second-level interpretation that followed the completion of the action-research groups (Chapter 2), in the form of a paper that has been submitted to a peer-reviewed journal. The paper summarises the study and the action-research process and outcomes, with a focus on examples from participants to support the interpretation.

In this paper I argue that action research can be used as a policy-development tool. I describe the outcomes of action research as a policy-development process and as beneficial to participants. The paper uses participant experiences to exemplify themes that emerged from the action-research process, and includes a discussion on the outcomes of the policy development process with a section on quality and limitations. I conclude the chapter with a summary of the paper and its place as a novel policy-development process.

4.2 Published Findings

The manuscript was submitted for consideration for publication to the journal Health Policy on 5 March, 2016. I am currently awaiting the outcome of the submission. The manuscript is presented in the format required for the journal, including headings and numbering that relate to the individual article, outside the exegesis sequence.

Co-creation of an Allied-Health Clinical-Supervision Policy: A participative approach

Abstract

This paper reports the findings of an action-research project that was undertaken to develop an allied-health clinical-supervision policy. The resulting understanding of the clinical-supervision experiences of 113
allied-health professionals was used as a foundation to create a clinical-supervision policy. The policy was developed through an iterative action-research process. During the action research, 43 health professionals were involved in developing policy and learning about clinical supervision. The policy development was driven by the needs of the participants. This intensive engagement co-created a tailored supervision policy that incorporated and determined actions to meet the needs of individuals and the health organisation through empowerment and education, thus increasing ownership of the policy and its likely success upon implementation. The authors argue that use of action research as a policy-development process is inclusive and participatory.

1.0 Introduction

Clinical supervision is a workplace activity that involves more-experienced health professionals providing those less experienced with support and guidance to improve the quality and safety of their practice, and facilitating their learning in the workplace [1, 2]. Clinical supervision plays an important role in clinical governance by ensuring client safety, and it is significant to professional satisfaction and retention [3-5]. Key attributes required for successful clinical supervision include an effective supervisory relationship [6-11], accessibility of clinical supervision [7, 8, 12-14], recognition of the needs of the supervisee [15] and clarity of purpose, function and form of clinical supervision [7-9, 15-18].

Obtaining clarity about what clinical supervision means is essential to developing consistent and sustainable clinical supervision, and structure is one way of achieving this [13, 19]. Clinical-supervision policy and guidelines are one structure that can improve clarity [19]. There appears to be an absence of policy and leadership about clinical supervision in health organisations, and this situation can result in a lack of direction [19-21]. Policy-making can also have greater impact than less formal approaches, because failure to adhere to policy may result in sanctions [22-24]. Policy provides a mechanism for ensuring that the attributes and elements required for effective clinical supervision are implemented into
practice. A clinical-supervision policy can improve the quality and efficacy of clinical supervision through the establishment of agreed ways of working and clarity of purpose and function [1, 19, 25, 26]. Collaboration, participation and involvement of the intended recipients in the construction of the policy are paramount during its creation [27-30].

Action research, as a participative approach, was used to facilitate policy development in this study. Action research is appropriate for workplace research, such as clinical supervision, especially when focused on making changes within that community [31]. Action research has been used to develop public-health policy [27, 32, 33] and to understand and improve client organisations [34, 35]. This study involves allied-health professionals as policy users, which differs from studies in which clients and clinical service-users are the policy users and central point of engagement in policy development. Some authors have argued that it is important to engage health professionals in the development of policy; however, there appears to be limited use of action research as a strategy for creation of clinical-supervision policy [36, 37].

The goal of the present study was to develop a policy of clinical supervision that could be readily accepted and implemented by the people who would use the policy. Action research was therefore considered an appropriate and useful approach. The purpose of the policy was to address the clinical-supervision needs of the group of health professionals, to ensure a consistent approach to clinical supervision and to serve as a guiding document for implementing supervision. This paper will describe and discuss the policy-development process, and use examples from the developed policy to demonstrate the effectiveness and outcomes of the action-research process.

2.0 Materials and Method

Action research is a qualitative form of research that can be used to change practice through a repeating spiral of reflection and action [38]. Stringer's (2014) Action Research Model distills the action-research
process into a repeating spiral of: Look, Think and Act [39]. In this study, this spiral was used across five cycles in three geographical groups, in a repeating sequence to structure the action research process (Figure 1).

Action research focuses on problem-solving, knowledge generation, reflection and learning, with the aim of creating change [40]. Action research also seeks to improve the quality of an individual’s, a community’s, or an organisation’s experience through empowering participants. This empowerment occurs as a result of group involvement and collaboration in identifying problems, decision-making, evaluating information, and planning action [41].

**Figure 1. Action research spiral**

![Action research spiral diagram](image)

### 2.1 Participants and recruitment

The health organisation participating in this study included rural, regional, outer metropolitan and metropolitan locations in New South Wales, Australia. Purposive sampling was used to recruit allied-health professionals who had an experience of clinical supervision on either or both sides of the supervisory dyad. All allied-health employees who had received or provided clinical supervision in their professional careers were eligible to participate. For the purpose of the study, the term *supervisee* identified any allied-health professional who had received supervision as an individual or within a group, from peers and/or a senior health professional. The term *supervisor* was used for any allied-health
professional who had provided group or individual supervision to any other health professional.

Participants were invited to participate in an anonymous survey and a series of action-research groups. Potential participants were informed about the survey and the action-research groups through an internal organisational email.

Approval from Charles Sturt University, Australia Human Research Ethics Committee and Wollongong University, Australia Research and Ethics Council was sought and granted.

### 2.2 Data-gathering

Data was collected in two stages. First, data was collected through using Survey Monkey, a web-based survey tool available at www.SurveyMonkey.com, which was used to administer and collect the surveys. The survey included questions about the respondents’ prior experiences of supervision and key elements for effective and high-quality clinical supervision. The aim of collecting this data was to summarise and report the results to allied-health professionals for their consideration within the action-research groups.

The second stage of data collection was through action-research groups, which were conducted in three geographical locations spanning the health organisation; five group meetings were conducted in each location over a nine-week period, for a total of 15 meetings. An individual participant, however, would only have attended between one and five times. Group membership was open; that is, participants were not required to commit themselves to attending all five group sessions, and new participants could join at any stage.

Following each action-research cycle, the researcher summarised the outcomes and content of the group meetings in a newsletter and emailed it to the allied-health professionals employed by the health organisation, including those who had not taken part in the current (or even any) cycle.
The suggested topics and content for the subsequent round of groups were also outlined to assist participants with preparations for the next cycle. Each session was audio-recorded, and the group facilitator also took notes during each group.

The researcher (the first author) analysed data from the survey and action-research groups to identify themes. First, the researcher organised notes from the discussions, audio recordings of groups, the researcher’s reflective diary entries and newsletters into texts. After reading and re-reading the texts to identify important idea or statements, the researcher created categories for these important ideas. Categories were connected and emerging themes named when common ideas and concepts were identified. Van Manen (1997) described themes as a structure that relates meaning [42]. Identifying categories that could explain the meaning of all results within them resulted in the creation of overarching themes. The researcher used the newsletter to convey the themes to the allied-health professionals.

3.0 Results

The survey participants had a breadth of supervisory experience, with 37% identifying as supervisors, 42% as supervisees and 21% as both. Of a total professional allied-health group of approximately 1,350 clinicians, 113 volunteered to participate in the anonymous survey. Forty-three agreed to participate in the action-research groups: 23 outer-metropolitan participants, 15 regional participants, and five rural participants.

Through this study, a clinical-supervision policy was developed (5.4), and the allied-health professionals for whom the policy was created were actively engaged in its development. The policy consisted of 12 key principles paired with explanatory guidelines for assisting with implementation. The key principles, which were developed during the focus groups, are summarised in Table 1.
<table>
<thead>
<tr>
<th>COMMITMENT TO</th>
<th>Clarifying statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principle</td>
<td>1. Training</td>
</tr>
<tr>
<td></td>
<td>All professionals performing a supervisory role have access to and are resourced to attend generic supervisory training.</td>
</tr>
<tr>
<td></td>
<td>2. Defining frequency and type of supervision</td>
</tr>
<tr>
<td></td>
<td>A range of supervision options is available to all professionals.</td>
</tr>
<tr>
<td></td>
<td>3. Transparency and consistency</td>
</tr>
<tr>
<td></td>
<td>Policy application and accessibility of supervision is transparent and consistent throughout all allied-health departments and professionals.</td>
</tr>
<tr>
<td>ENTITLEMENT TO</td>
<td>Ongoing supported learning and support for the supervisee in the professional-personal interface is provided.</td>
</tr>
<tr>
<td>1. Support</td>
<td>Access to supervision occurs regardless of experience, number of hours worked per week, geographical location (including isolation), caseload or status in the organisation. Access is regular and facilitated.</td>
</tr>
<tr>
<td>2. Accessibility</td>
<td>Input is developed in consultation with line managers and organisation</td>
</tr>
<tr>
<td></td>
<td>requirements. Consideration might be given to supervisor rotation.</td>
</tr>
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<td>---</td>
<td>---------------------------------------------------------------------</td>
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<tr>
<td>4.</td>
<td>Supervisee-centred supervision</td>
</tr>
<tr>
<td></td>
<td>Consideration is given to supervisee learning style, aimed at supervisees’ learning and based around issues brought to supervision by the supervisee. To this end, the supervisee comes to supervision with adequate preparation. Supervision occurs within a negotiated safe, comfortable environment.</td>
</tr>
<tr>
<td>5.</td>
<td>Good supervisory relationships</td>
</tr>
<tr>
<td></td>
<td>The supervisory relationship reflects aspects of trust, reliability, approachability, honesty, non-judgement and open communication.</td>
</tr>
<tr>
<td>6.</td>
<td>Feedback</td>
</tr>
<tr>
<td></td>
<td>There are formal negotiations for feedback. Feedback is two-way. Specific systems for supervisee-to-supervisor are in place. Feedback is constructive, with the aim of supporting supervisee learning, critical thinking and problem-solving.</td>
</tr>
<tr>
<td>7.</td>
<td>Documentation</td>
</tr>
<tr>
<td></td>
<td>Documentation includes any record of the supervisory session as well as contracts made between supervisor and supervisee and supervisor reports. Documentation is about learning, obstacles to</td>
</tr>
</tbody>
</table>
learning, facilitators of learning and goals for learning.

8. Confidentiality
Requirements for maintaining the confidentiality of supervisory sessions are integral to the supervisor-supervisee relationship, and a point of accountability for both.

9. Learning
Learning is at the centre of supervision. Adult learning principles are at the core of all supervision activities and facilitate a commitment to ongoing learning and practice based on evidence.

**Table 1 – Key clinical-supervision principles and guidelines**

The participants' process of engaging in policy development is described according to five themes: reflection, learning, shared understanding, problem-solving and decision-making.

**3.1 Reflection**
Reflection occurred in every cycle. Reflection on past experience helped the participants clarify the key issues they thought ought to be included in the policy.

During reflection, the participants recollected and shared their experiences of clinical supervision. For example, a participant from the first cycle reflected on how lack of supervision as a newly graduated clinician negatively influenced her work performance.

“I remember when I was a new graduate... feeling very stressed if I didn’t have access to supervision, and the efficiency of my work was much poorer anyway because I was anxious and I wasn’t sure about my
decision – I would second-guess my decisions. I’d go back and I’d read my notes again and then I would call people or colleagues at night time who were new grads anyway, and I ask[ed] their opinion and it would just do this big spiral… because my supervisor was busy at that time and so we just, the whole thing just compounded. And I’d try and get research and I’d look on the Internet. I’d try and read a journal article but I wouldn’t have any direction. It’s actually quite time-consuming, I actually didn’t achieve much at all.”

3.2 Learning

As the participants reflected and shared stories within and between their groups, they developed a new shared understanding of supervision. The participants learned about clinical-supervision practice from each other and from the available literature. This learning across the groups was demonstrated in the changes to the aim of the clinical-supervision policy. The aim evolved by cycle 5 to include a clear understanding about what clinical supervision was and was not, as illustrated in this excerpt from the clinical-supervision policy:

- Clinical supervision is not: punitive, negative, performance management, performance appraisal or just about competence or attendance at organisational meetings or a counselling session.

- Clinical supervision is: knowledge-sharing, education, guidance, clinical, learning, encouraging clinical development, providing feedback and support [43].

3.3 Shared understanding

The participants created a shared understanding of clinical supervision in allied health by reflecting on whether the principles would meet the needs of all allied-health professionals. The participants often told stories of their own supervision experiences to facilitate developing this shared meaning between them. For example, the following interaction from group 2 demonstrates the participants grappling with how to engage all professionals in supervision:

P1: I know there are a few people in my department, like older people, you know, who are going to be really reluctant to participate [in clinical supervision], – you know, like, ‘I’ve been doing this [clinical work] for 30 years, so why do I even need to do this [clinical supervision]?’
P2: Yes, I agree. In my profession, which is very small, I am the only senior in the department. I have a number of older professionals who really avoid coming to me for supervision or to ask advice, and I can’t help but think this is because of my age. I am much younger than they are, and so they avoid coming to me for advice. They, like, go around me and stuff like that, like they go to other people they think are older than me. They think that, like, just because I’m young I don’t know enough or I don’t have enough experience, but, like, I know more than they do about some things. It’s really difficult to manage.

3.4 Problem-solving

When problems were identified, the participants carefully discussed the situation until agreement was reached. For example, following is an exchange from group 1 regarding the concept of what to document about clinical supervision.

Facilitator (F): So last time we were discussing documentation and whether there needed to be a standard, and we agreed what would be considered documentation. What do you think needs to be included in the documentation? Should it be mandatory, and who would be in charge of this?

P1: People don’t want detailed minutes of the meetings…but I think it needs to be negotiated, what are the goals and the outcomes and which way we are moving forward; I don’t think people have a problem with that.

P2: There needs to be some guidelines about what would be an okay amount to document.

P3: Yeah, it would clarify what is needed [in documentation] and then some scenarios in the training. Like, if someone did ask you not to document this, what do you actually say to them, because it is an awkward situation and I’d be, like, “No worries at all.”

P4: I have a problem with keeping any detailed minutes or even having any documentation at all. I think that it demolishes the trust that develops in the supervisory relationship and it would be impossible to be able to open up in supervision if you knew someone was taking notes about you and could use them against you later.

P1: There needs to be some record of what went on, or how could you even remember from time to time what you talked about?

P2: Well, it’s all about the supervisee, so they are the ones keeping a record.

P3: So why not just have the supervisee record the notes, would that do?
P1: No, I think that there needs to be some accountability in those notes in case something comes up later.

P4: Exactly why the trust would be decimated.

P1: Well, we have to have some documentation, I think, and it needs to be specified so that we have the same for everyone. Perhaps it doesn't need to be very detailed, and we can make allowances for supervisees to decide who writes the notes and things like that.

Agreement was reached in the next cycle, facilitated by the progressive nature of the discussion and mediated by the action-research spiral.

3.5 Decision-making

Decisions were made by consensus within each group and across groups, and were often developed progressively from one group to the next. For example, the following dialogue from group 1 illustrates part of the group decision-making about what ought to be included in the policy:

F: The policy format doesn’t usually have explanation about how to implement it; usually that goes into a procedure. So you are saying that you want these explanations to go into the actual policy itself?

P1: Yeah, so that everyone knows how to do the things that we are talking about. Like, if you tell someone they have to do something then they will be, like, “Oh, but how do I do that,” and we can be, like, “Oh, it’s in the policy. Just read the next bit” – like that. If you want someone to use it [the policy], it has to make sense to them, and they shouldn’t have to ask any questions or look somewhere else to find out.

P2: Yeah, I agree with that, so that we decide what goes in there. Why put it somewhere else? Because we are just answering the questions that they [other participants in the groups] have been bringing up, and so we know that others are going to ask the same things, don’t you think?

P1: Yes, that’s right.

F: So are you saying that you want to have the principle and the describing sentence, and then the explanation about how to implement it following that, all within the policy?

P1: That’s right.

P3: Yes, exactly that.

F: I will ask if we can do that, and will bring this to the other groups for discussion as well.
The suggested action and issues were discussed in group 2 and repeated with group 3. Eventually, all groups agreed on the action. Thus, the decision-making process was transparent, which enabled the groups to come to consensus on decisions and to participate fully in the decision-making process.

3.6 Outcomes of action research

As a consequence of engaging in the action-research process, the participants engaged in reflection, followed by learning new knowledge and developing a new shared understanding of the problem. This engagement resulted in barrier identification, solution creation and decision-making. Thus, the action-research sequence structured the policy-development process.

In summary, through action research, the participants were able to engage in an inclusive and collaborative process to develop a clinical-supervision policy. Through reflection, learning, developing shared knowledge, problem-solving and decision-making, the participants were actively engaged. They reported enjoying the opportunity to contribute to policy development, and their substantial involvement is likely to have assisted them in having a strong sense of ownership of the final policy.

4.0 Discussion

4.1 Benefits of using action research as a policy-development tool

This study provides an example of how action research may be used as a practical policy-development tool. Lynch and Happell (2008) identified that clinical-supervision policy implementation could be facilitated by employing the help of enthusiastic senior nursing colleagues; however, these authors also recognised that it was important to include health professionals at all levels of the organisation when implementing clinical supervision [19]. There is a parallel between the process described in the present study and Lynch and Happell’s (2008) six-stage model for implementing clinical supervision [2]. Shared characteristics include:
assisting in assessment of the organisational culture, obtaining organisational support, developing and executing a strategic plan and engaging in reflection [2]. The present study extends Lynch and Happell’s (2008b) work by including implementation strategies as part of the policy.

The present study illustrated that action research can facilitate policy implementation through engaging with participants and empowering them to direct the policy-development process. Previous studies by Lakeman and Glasgow (2009) and Ross (2013) identified barriers to clinical supervision such as negative professional attitudes and unsupportive organisational culture [13, 47]. The present study was able to overcome such barriers through fostering collaboration and inclusion in the policy-development process. A less consultative approach may not have revealed the challenges to policy implementation. Whitehead and McNiff (2006, p.12) emphasised that a collaborative approach is necessary when change is required: “sustainable change happens when people create and implement their own ideas rather than only accept and implement the ideas of others” [44]. The collaboration and knowledge-sharing that occurs in action research enables participants to develop a new awareness, and empowers them to determine what knowledge is useful and to act upon this independently [40].

Action research produced outcomes that were relevant to participants because the outcomes were based upon their own experiences, needs, problems and solutions. Similarly, Fletcher (2011) used action research with Australian Aboriginal health workers to develop a smoke-free-workplace policy that highlighted the importance of focusing on both process and outcomes in policy development [45]. It is the authors’ contention that as action research enables the development of a policy that is strongly relevant to participants, it is a highly appropriate tool for collaborative policy development.

Although action research is a time-intensive method of creating policy, it is similar in cost when compared to other policy-making processes. Kusserow (2014), in his paper on improving policy and procedure
compliance, estimated that each policy created by an organisation costs $5,000 regardless of who is involved in writing the policy [46]. The costs of wages for participant and researcher for the present study were approximately $4,650, and when travel costs are included, there is close alignment with Kusserow’s cost estimate.

The present study found that using action research in policy development resulted in positive benefits that included participant learning, problem-identification and problem-solving, as well as creating ownership of the policy. Thus, the authors suggest that action research can be a valuable policy-development and implementation process for clinical supervision.

4.2 A policy that could be accepted and implemented by policy users

In the present study, both principles and guidelines were built into the same policy; thus the policy functioned as a comprehensive guide to clinical supervision in allied health. In contrast, Collins and Patel (2008) argued that a policy ought to be differentiated from guidelines, because policy mandates compliance, whereas guidelines only require broad adherence [24]. Thus, the present study provides an alternative view to how to construct policy.

The present study provides an innovative model for policy development, as it differs from the traditional method of policy formation, which is for an individual policy author to take carriage of policy development in consultation with other stakeholders [24]. Stakeholders were empowered to be collaborative policy authors in the present study. Similar to this study, Kusserow (2014) recommended involving all those affected by a policy in policy development, as their engagement facilitates achieving policy compliance [47].

5.0 Research quality and limitations

Quality issues in the present study were addressed through prolonged engagement with participants, triangulation of data and member-checking. Prolonged engagement creates a space for all voices to be heard and for
inconsistencies in outcomes to be identified and investigated [47]. The researcher spent 10 weeks in the action-research process, collecting and analysing data and discussing findings with participants. Triangulation of data sources is when multiple sources of information and different participants and techniques are used to ensure that more than one understanding of the experience under investigation is available [47, 48]. In the present study, triangulation was achieved by collecting information via a survey and action-research group discussions. Member-checking allows participants the opportunity to examine if the themes and interpretations offered by the researcher resonate with their experiences [47, 48]. Member-checking was achieved in the present study by actively involving the group participants in the policy-development process. In another form of peer validation, the complete draft policy was also distributed to all allied-health professionals, and comments about it were invited prior to its formal ratification.

A limitation of this study was that the principal researcher had a dual role of researcher and an allied-health department leader within the health organisation that was the focus of the research. The researcher openly acknowledged the possible power inequity between her and the participants in each group. The researcher was not the direct discipline manager for the majority of participants, which reduced the possibility of direct intimidation. For those health professionals within the researcher’s own department, the researcher was a familiar colleague with whom to discuss clinical supervision openly. For others, the researcher monitored her own responses more carefully and reminded the group that anonymous comments could be placed into a designated “comments” box adjacent to the exit. The researcher always busied herself away from the exit at the completion of each session. To mitigate problems of power inequality, anonymous participation in the survey was used, and participants were offered the option of attending multiple sites for action-research groups. This gave participants the option to attend a site distant from co-workers or supervisors where they may have felt intimidated about being open with comments or feedback. The researcher reassured
participants that their comments during the group would be treated confidentially and there would be no pejorative outcomes as a consequence of their participation.

6.0 Conclusion

A principal finding of the present study was that action research could be used to develop a policy about clinical supervision. Using action research fostered collaboration, learning and a sense of ownership of the resulting policy amongst the health professionals for whom it was intended. Therefore, the authors recommend that policy development that fosters engagement and collaboration, such as action research, may be useful for developing policies that are both effective and used widely and consistently. If such an approach is adopted, the end-users of policies will write and develop their own policies. Thus these policies may be more likely to be viewed as existing to enhance practice rather than as being imposed on them from external forces that are removed from daily practice.


4.3 Chapter Summary

This chapter highlights the policy-development process using action research. It presents the benefits of action research and how and why these could be used to facilitate clinical-supervision implementation. This chapter describes the policy-development process in detail so that an
evaluation can be made as to its suitability in other settings and situations. Participants’ responses are used as direct quotations in this chapter to enhance the credibility of the study and to offer the reader an opportunity to engage with its believability, asking themselves if these results resonate with their particular environs. This part of the research process was concerned with identifying the needs of the allied-health clinicians and acting on them to create practical ways for the needs to become practice. Policy is the structure that made enacted these needs.

In this chapter I have described some significant findings of my study. The findings in this chapter demonstrate action research as a useful policy-development tool in allied-health clinical supervision and expands on previous studies that have used collaborative and inclusive processes to develop policy. Several studies have used action research to examine clinical supervision in medicine and nursing; however, there have been none in the field of allied health and none to develop policy (Deery, 2005; Hill & Melender, 2015a; Lakeman & Glasgow, 2009; Saucier, Paré, Côté, & Baillargeon, 2012). The use of policy to structure clinical supervision through an action-research process is a novel addition to the literature.
CHAPTER 5: A CLINICAL-SUPERVISION POLICY FOR ALLIED HEALTH

5.1 Introduction

In this chapter, I will present the clinical-supervision policy resulting from the action-research groups (5.4). I will present the policy in the form of a findings chapter to recognise the importance of the policy content and structure, in relation to the outcomes and implications of my study. A requirement of this doctoral study is an outcome that influences practice. I thus present the clinical-supervision policy as one outcome of my study that can influence clinical-supervision practice.

The purpose of this chapter is to elaborate and annotate the details of the clinical-supervision policy developed in the action-research groups. I will discuss the form and the content of the policy. The policy-development process was discussed in depth in Chapter 4. Where I discuss the policy development process in this current chapter, it is used to clarify the purpose or reasoning of the structure or content of the policy.

To reflect the policy form, I will use the headings and numbering from the policy, in the order in which they occur. Italicised excerpts from the policy will be used to present the policy text, and discussion will occur in relation to the development of the form and content of the text.

5.2 The Clinical-Supervision Policy

The participating health organisation had templates for the formatting of health policies. The given headings were initially used by the action-research groups to broadly structure the policy development process. The resulting policy has three general sections: a definition of the aims, audience, responsibilities and policy statement; a statement of 12 key principles of clinical supervision; and a set of three templates as an appendix to the policy document (5.4, 5.5).
The policy statement

The policy statement is deliberate statement that declares the intentions or purpose of the health organisation. The statement *All allied Health staff are entitled to, and will receive, clinical supervision*, achieves this first by focusing on the people to whom the policy applies; second, by stating that it is clinical supervision that will be applied; and third, by using the words *entitled and will receive* to give clarity to the organisation’s commitment to the provision of clinical supervision. Entitlement and commitment are two words that consistently emerged throughout the study, and thus informed and influenced the form and content of the policy. The groups felt very strongly that they were entitled to clinical supervision, and that this related to issues such as support, feedback, good supervisory relationships, choice of supervisor and quality of supervisors. Participants also felt strongly that clients were entitled to safe, quality, ethical practice.

The word *entitle* might give an impression of demand; however, its beginnings were based in a shared experience of being denied clinical supervision. This was described as overt obstruction to access, emanating from a belief that clinical supervision was not a necessary part of good clinical practice in the health organisation at that time. Participants wanted permission to participate in clinical supervision and to have its significance recognised in clinical practice. Participants easily agreed that the word “entitled” conveyed the concept of having “permission” to participate in clinical supervision. The definition of entitlement is to give a person “a just claim” or “a right” (Australian Concise Oxford Dictionary 5th Ed., 2009, p. 469). Participants used the word “entitled” to give themselves permission to make this “just claim” on something that was so important to them; it was “a right” they could claim because of its significance to both health professionals and clients.

Participants chose the word “commitment” as it represented a promise not just from health professionals, but more importantly to them, from the organisation. The word commitment required recognition from the health organisation that clinical supervision was an important part of clinical
practice, and that access was integral to this recognition. Health professionals were required to prepare, provide and attend clinical supervision.

Following cycle 4, the clinical-supervision policy was in full draft form, and was presented to the health organisation’s policy representative to ensure that it complied with the organisational requirements for policy publication. There were two feedback points. First, the inclusion of the implementation guidelines in the policy document was not customary formatting, as these were usually separate documents. I discussed the importance of ownership of both the form and content of the policy, and of the groups’ suggested formatting, to successful implementation. The second feedback was an attempt by the health organisation to align the structure of the policy with its purpose; that is, to actively engage health professionals in clinical supervision. This resulted in suggested changes to the words *entitlement*, which the policy representative suggested changing to “provision”, and *commitment*, which the representative suggested changing to “participation”. The reason given was that this would make the policy easier to implement. Following discussion across all groups, the suggested changes were accepted by the group as a whole, as they judged that the critical elements of the policy, such as including implementation strategies within the policy and ensuring a promise to support access to clinical supervision, were retained. The words themselves gave way to their symbolic meaning, and were therefore able to be released.

This decision is reflected by the words “entitlement” and “commitment” not featuring heavily in the final draft of the policy. The word “committed” remained as a descriptor of the two types of principles, and “entitled” appeared in the policy statement, most notably in policy sections 7.1 and 7.2:

7.1 *...the District is committed to three principles in the provision of clinical supervision for allied health staff;*
7.2 ...the District and Allied Health staff are committed to nine principles for participation in clinical supervision.

This conveyed the meaning of the promise to uphold the content of the policy.

Aim

The aims of the policy describe what is to be achieved by the policy implementation. The aim statement was progressed across the group cycles and clarified through each cycle, and through the subsequent discussions and decisions. The aims were an important part of asking the policy whether it was doing the job it was meant to. The stated aim of the policy was to provide regular, consistent, high-quality clinical supervision to all allied-health staff. This provided a focus for what was important in the policy: the regularity, consistency and quality of the clinical supervision to be provided. Following this statement, qualifiers were added to explain the outcomes of the aims. These would enable the policy user to question the clinical supervision provided, asking whether it would:

- Enhance clinical skills,
- Enrich knowledge and best practice and
- Encourage clinical development and provide feedback and support to further develop clinical skills, and thereby ensure provision of an up-to-date and evidence-based service for all clients.

Target audience

The target audience for the policy was all allied-health staff within each facility of the health organisation. Thus the policy functioned as an overarching statement of minimum requirements for these health professionals. The policy explicitly stated that it did not override specific professional requirements.
Responsibilities

Clearly stating in the policy who is responsible and for what was an opportunity to define individual and organisational commitment to clinical supervision. The statement of responsibilities was detailed and specific about expectations and accountabilities, and included measurable outcomes. Although 100% compliance was seen as aspirational within the groups, it was impossible for participants to agree on which percent of the allied-health profession it would be acceptable to not have access to clinical supervision. Compliance with the policy was mandatory, which required a goal of 100% compliance. Thus it was stated:

Allied-health heads of department are responsible to ensure that 100% compliance with the policy is observed (including training of supervisors) and that reporting of compliance is completed every six months to the appointed allied-health executive.

Further leadership expectation were required:

The District Executive will support Allied Health Heads of Department in ensuring that:

• All allied-health staff have access to clinical supervision.
• All supervisors attend training before commencing supervision of staff.
• Documentation of a contract/agreement occurs for every supervisee.
• Minimum standards of documentation are observed.
• The District retains ownership of supervision notes via the supervisor.
• Attendance and participation occur.
• Training is provided at regular intervals.

Individual responsibilities were clarified for those engaging in clinical supervision:

Supervising staff – to ensure that all aspects of the policy are adhered to and that time commitments to supervisees are as per the clinical-supervision policy.
Supervisees – to participate in clinical-supervision activities for 1 hour every calendar month.

These responsibilities evolved across the groups as a clear connector between the requirements of the policy and those enacting it.

**Definitions**

Definitions were created to explain what was, and was not, included in clinical supervision. Further clarification of specific terms ensured a shared understanding across the health organisation. The groups drafted a definition of clinical supervision in the early action-research cycles, which became more detailed as the cycles progressed. This characterised clinical supervision as an activity and a process:

*Clinical supervision is an activity of professional support and learning that empowers individual practitioners to develop knowledge and competence, maintain responsibility for their own practice and optimise safety and quality of care in complex clinical situations. The process of clinical supervision involves knowledge-sharing, education, guidance, a clinical focus, learning, encouraging clinical development and the provision of feedback and support.*

Further to this definition, the groups decided it was important to overtly define what clinical supervision did not encompass. This was reflective of the experiences of the participants and the frequency with which these unwanted elements had appeared in their own experience of clinical supervision:

*Clinical supervision is not: punitive, negative, performance management, performance appraisal, just about competence or attendance at organisational meetings or a counselling session.*

Further definitions included the supervisor and supervisee in the meaning of a clinical-supervision contract or agreement.

*Supervisor – any allied-health professional staff member required in their position description to perform supervision.*

*Supervisee – any allied-health staff member who is receiving supervision.*

The inclusion of a contract or agreement as a necessary part of the clinical-supervision process within the policy was recognised as something
that may have been new to the policy users. For this reason, participants defined the terms “contract” and “agreement” to ensure consistency of understanding and approach.

Contract or agreement – a written formal agreement between each supervisor and supervisee, outlining the agreed conditions of supervision.

Examples or templates for a clinical supervision contract or agreement appear in Appendix 3a of the policy.

**Documentation**

The occurrence and form of documentation as a record of supervision was a subject of fervent discussion between participants. It was thus important that decisions made within the action-research groups and suggested processes for documentation were reflected as key examples or templates in the policy. This gave form to the key decisions made, such as the need for a contract or agreement to be in place (Appendix 3a), the requirement for minimum expectations for documentation (Appendix 3b & 3c) and the central place that giving feedback to one’s supervisor has in quality clinical supervision (Appendix 3d).

The **allied-health contract for clinical supervision** (Appendix 3a), provides a suggested template that illustrated the outcome of discussions about the ownership and power imbalances in clinical supervision. This template gives the option to discuss who completes the documentation, what is documented, where this documentation occurs and is stored, a brief summary of the expected content of the sessions and agreements for commitments and co-contribution from both supervisor and supervisee. Details of frequency, location and length of sessions is also a suggested inclusion.

The **allied-health clinical-supervision minimum standards for documentation** (Appendix 3b) expresses the specific requirements for documenting clinical-supervision sessions. These requirements are expressed both as a list of minimum standards for documentation and a suggested template for incorporating these minimum standards. These
standards, which resulted from discussion about the content and outcomes of clinical supervision and the need for specific and consistent documentation, include the following nine items:

6. Broad subject topic
7. Minimal identification of staff or clients (Medical Record Number might be used where appropriate)
8. Clear review of set goals and objectives
9. A focus on and around achievement of clinical goals and facilitators or barriers to these
10. The date that the clinical supervision occurred
11. A copy to be provided to both supervisor and supervisee, within seven days of the supervision occurring (this may be a paper or electronic record)
12. Documentation confirmed for accuracy prior to commencement of next session on review of clinical-supervision record, with any comments or additions
13. Changes in practice/application of knowledge
14. A log of hours attended

The template formed a user-friendly option to ensure all standards were met (Appendix 3c).

The allied-health clinical supervision – supervisor feedback form (Appendix 3d) resulted from group discussions about the need to ensure quality of clinical supervision. The groups decided that feedback to one’s supervisor was less likely to occur without an explicit process. Discussions included decisions about whether such feedback should be conveyed face to face or anonymously, as participants had described supervisees’ possible reluctance to give honest opinions and feedback in an evaluation, due to the possible power imbalance in the supervisory relationship. Discussions about the mode of delivering the feedback included the need to commit to giving feedback as a regular part of clinical supervision, and
conversely that honest feedback may not be possible if done face to face. The drawback of anonymous feedback was discussed as a lack of ownership of the feedback, leading to unusually harsh and possibly unhelpful words about the supervisor. These discussions culminated in a feedback form that incorporated a feedback scale aimed at reducing harsh judgement, stated as meeting few/some/all of my needs.

The form is divided into four sections that relate to the early categories that emerged in the survey and cycle 1. These were: structure of supervision, supervisor quality, supervision quality and challenges to supervision occurring. In this way the group determined that all of the known issues and possible barriers known by the group at that time were addressed within the feedback form. Prompting questions were included in each section, which resulted from feedback from new participants in the action-research groups who had found the meaning of some statements unclear. Sections 1 to 4 are described in the context of the key issues identified.

Section 1 – structure of supervision requested feedback on documentation and whether it was appropriate and completed regularly; confidentiality and whether content was appropriately managed; and clarity of the supervision process and whether discussion around the process and roles had been clarified.

Section 2 – supervisor quality addressed issues of adequacy of support; the functioning of the supervisory relationship; and whether the environment was conducive to revealing errors in one’s own practice. The adequacy of the supervisor’s knowledge, skill and expertise was included, as these were seen as the facilitators of supervisee learning goals. The degree to which a supervisor encourages my own problem-solving through prompting and allowing the space to do so was deemed to be an important indicator of supervisor quality. Approachability was determined to be the final barometer for supervisor quality as determined through an evaluation of the supervisory relationship.
Section 3 – supervision quality aimed to evaluate three aspects of supervision: the appropriateness of the supervision environment or setting, as an indicator of whether there is dedicated space and time allocated; feedback quality; and feedback frequency. The latter two questioned the frequency, content and helpfulness of the feedback received in clinical supervision.

Section 4 – challenges to supervision occurring questioned the supervisor’s availability for and dedication to clinical supervision time, punctuality and the consistency of appointments, examining whether the agreed frequency was being consistently maintained.

The form asked the supervisee one final question: how has this clinical supervision affected the way you practice? Participants decided that this question could summarise, for the supervisor, the effectiveness of the clinical supervision provided, through an acknowledged change in the supervisee’s clinical practice.

Whilst the broad headings of the policy complied with those given by the health organisation, the subsequent form of the words under the headings and the content within each were decided by the groups. The groups decided on important inclusions within the policy by ensuring that all information was useful and relevant to the user of the policy. Whilst these were not required by the organisational policy format, they were important inclusions for participants in documenting and sharing their vision of the ideal supervision journey.

Principles for The Provision of/Participation in Clinical Supervision

The survey outcomes and interpretations were distributed to all action-research group participants one week before each session. In cycle 1, participants were able to understand the survey experiences and integrate them with their own. This generated labels for experiences, including naming the barriers and facilitators to clinical supervision. My interpretation of the first action-research cycle generated four preliminary themes: supervision structure, supervision quality, supervisor quality and
challenges or threats. These identified themes formed the basis of the 12 principles for clinical supervision for this group of allied-health professionals.

As a result of negotiations with the policy representative, two types of principles were developed: three principles for the provision of supervision and nine for participation in supervision. The groups discussed the role these principles would play in the presentation of the policy. The decision to use the principles to shape the policy document was made across all groups. The purpose of the principles was to identify and describe the most important features of successful clinical supervision. It was important that the principles were based in experience so that the resulting policy was relevant to those who would use it. Thus the 12 principles outlined both the form and the content of the clinical-supervision policy.

Each principle was stated simply and in a few words; for example, provision principle 1 was stated as “training and education”. A further decision was made to clarify each principle with an initial descriptive phrase or statement. Provision principle 1 read, “All staff performing a supervisory role have access and are resourced to attend generic supervisory training.

New participants to the groups who had not taken part in previous discussions, however, found it difficult to fully understand each principle. A descriptive paragraph was consequently developed to detail the meaning of and inclusions under each principle. For example, provision principle 1 was described as follows:

*Supervision training should include information on documentation standards, confidentiality, adult-learning principles, feedback systems, organisational principles, guidelines and policy in relation to clinical supervision and rights and responsibilities. Supervisees should also receive information and education in relation to supervisee and supervisor expectations. This should occur as part of the local departmental orientation process. Discipline-specific training may also require compliance in accordance with professional associations and standards.*
As a consequence of understanding what each principle would mean, the natural progression was to ask how these could be achieved. The groups answered this question by recommending the development of a set of instructions that would guide the user in the implementation of the principles. These were later labelled *implementation guidelines*. For example, the guidelines for principle 1 read as follows:

*Implementation Guidelines*

*Any staff providing clinical supervision should have access to the minimum training requirement. This would be seen as a one-off requirement; however, it should not preclude access to further supervisory training. Requirements to provide clinical supervision would be outlined within position descriptions and would be mandatory for those staff. Departmental support for release of these staff is essential. Suggested inclusions for training are:*

1. What is clinical supervision?
2. How do you do it?
3. What are the requirements or mandates of the organisation’s policies in relation to clinical supervision?
4. Vignettes and examples
5. Role plays
6. Managing challenges
7. Allocation of supervisees and supervisors

Following are the remaining 11 principles for clinical supervision and their corresponding summarising phrases, explanatory paragraphs and implementation guidelines as they appear in the policy (5.4). Each principle was described in sufficient detail to enable a novel reader to understand the given principle, what it meant, what was expected and how to meet these expectations. Due to the large amount of text and self-explanatory nature of the text, I will present each principle in whole and follow with an annotation to give context to its placement and importance within the policy.
Principles for Provision of Clinical Supervision

The District is committed to three principles in the provision of clinical supervision for allied health staff.

The provision principles aimed to lay the groundwork for the clinical supervision that would occur. Training and education, defining the frequency and type of supervision and ensuring transparency and consistency of practice contributed to the establishment of essential knowledge or expectations prior to engaging in clinical supervision.

Provision Principle 1: Training and education (described as shown above).

Participants understood that training and education of both supervisors and supervisees was essential to providing high-quality clinical supervision. Minimum requirements for training were set to clarify expectations and ensure adequate skills and knowledge about clinical supervision in allied health.

Provision Principle 2: Defining frequency and type of supervision

A range of supervision options should be available to all staff.

As a minimum recommended standard, an hour of clinical supervision per month would be expected. This may include participation in any other supervisory activities, and individual learning needs would be considered when negotiating required time. Access to supervision via teleconference and videoconference should also be considered. Supervision might occur in both inter- and intra-disciplinary capacities. The stated frequency and type of supervision would not override specific professional requirements, such as those mandated by National Registration Boards. One hour of one-to-one/individual clinical supervision each calendar month is the minimum recommended requirement. Requirements for types of supervision will be set by individual professions through a dedicated business rule. Part-time staff may discuss a pro-rata or modified time commitment with the appropriate senior staff member.

Implementation Guidelines

A range of clinical-supervision options should be available to all staff. Individual clinical supervision should be made available to staff; however, other types of clinical supervision, such as group, peer, or ad-hoc telephone calls should be considered and may also be in addition to this time, not in place of it. Paid external supervision
might be considered where all internal options have been exhausted, at the discretion of the District Executive.

Participants defined the frequency and type of clinical supervision to be expected. This gave a shared understanding about what allied-health professionals could expect when they entered into a clinical-supervision arrangement. Participants supported a minimum expectation of one hour per month, which they had located within peer-reviewed literature and which, in their experience, they had found this to be a minimum expectation. A range of clinical-supervision options were given to ensure that geographical location or availability did not create a barrier to contact.

**Provision Principle 3: Transparency and consistency**

Policy application and accessibility of supervision is transparent and consistent throughout all Allied Health Departments and to all Allied Health staff. This will ensure consistency of supervision during rotation or change of site.

**Implementation Guidelines**

1. Clinical supervision dates, times and sites need to be set in advance and negotiated at the initiation of a contract/agreement.
2. Session boundaries, such as switching off telephones and pagers, should be clear.
3. Re-booking missed sessions should occur as soon as possible and should replace missed sessions, rather than waiting until the next scheduled session.
4. A substitute supervisor should be arranged when the supervisor is on leave.
5. There is an expectation of commitment from both supervisee and supervisor to put aside consistent time for clinical supervision.
6. Templates or minimum standards are used by all staff

Participants decided it was necessary to support a strong initial foundation for clinical supervision to ensure that the same approach and access to clinical supervision was provided regardless of where allied-health professionals were employed across the health organisation.

The District and Allied Health staff are committed to nine principles for participation in clinical supervision:
The nine participation principles present both the allied-health professionals’ rights, or what they could expect within clinical supervision, and their responsibilities, or what could be expected of them.

**Participation Principle 1: Support**

Provision of ongoing supported learning and support for the supervisee in the professional-personal interface. The principles of participation target the taking part or sharing in the clinical-supervision process.

**Implementation Guidelines**

There should be clarity around support boundaries. Contracts/agreements can be used to set clear boundaries around types of support that would be appropriate. Clinical supervision is not a counselling session; it has a focus on clinical work. Should any personal distress be identified or notified by the supervisee, the supervisee will be reminded of the availability of the service provided by the Employee Assistance Program (EAP), who provide strictly confidential, free, professional counselling to all staff for a broad range of personal or work-related concerns such as stress-related problems and work issues.

Support for supervisees was considered an important part of effective clinical supervision within the groups. The need to remain focused on the clinical work and supervisee responses to it was made clear by the action-research groups. The need to identify where this moved into personal distress was discussed, which clarified that clinical supervision was not effective when used as personal counselling, either because learning goals could not be met or the supervisor might not be appropriately trained in professional counselling. This principle attempted to clarify difficulties between distinguishing between appropriate supervisee distress in response to a clinical situation and significant personal distress.

**Participation Principle 2: Accessibility**

Access to supervision should occur regardless of experience, number of hours worked per week, geography or isolation, caseload or status in the organisation. Access should be regular and facilitated.
Implementation Guidelines

A variety of modalities for delivery of clinical supervision should be considered. These may include teleconferencing and videoconferencing. Communication with all line managers concerned regarding the agreements and commitments should occur. Times should be negotiated between all parties.

The accessibility principle addressed issues of equal access to clinical supervision across all professions and work environments within the health organisation. Part-time workers and those in rural settings relayed experiences of disadvantage in terms of access to supervision. Flexible modes of supervision delivery aimed to address this barrier to access.

Participation Principle 3: Input into supervisor allocation

Consultation should occur with line managers and supervisees, and should consider service requirements. Consideration might be given to supervisor rotation. The skills of the supervisor and supervisee should be considered when allocation occurs.

Implementation Guidelines

1. This should always occur in consultation with the supervisee, supervisor, line managers and service requirements.
2. A commitment to good supervisory relationships may require supervisor input into supervisor allocation.
3. Difficulties with allocation may occur; this may require negotiation with all parties concerned.
4. All efforts should be made to allocate a supervisor who is not the direct line manager of the supervisee.
5. Where this is not possible, separation of clinical and non-clinical supervision is paramount, and regular assessment of the success of the relationship should occur.
6. Attempts should be made to match the area of expertise and appropriate level of clinical knowledge.

Participants developed this principle in acknowledgement of the importance of supervisees’ involvement in supervisor allocation. Further discussions also presented issues of access to a range of supervisors and the need for a supervisee to be challenged, rather than choosing a supervisor with whom they were most comfortable. This principle also outlines the importance of making all attempts to separate clinical supervision from line management.
Participation Principle 4: Supervisee-centred

Consideration should be given to supervisee learning style, be aimed at supervisees’ learning and be based around issues brought to supervision by the supervisee. To this end, the supervisee should come to supervision with adequate preparation. Supervision should occur within a negotiated, safe, comfortable environment.

Implementation Guidelines

1. Supervisee’s learning styles and previous supervisory experiences should be identified.
2. Supervisee should be provided with an information sheet, instructing them how to prepare for a clinical-supervision session.
3. A contract/agreement template should be used to negotiate agreements, including aspects such as time, frequency, site and boundaries.
4. Supervisees should bring clinical cases or clinical topics/issues to the session for discussion.
5. Goal-setting should occur with the supervisee.
6. Clarity around time allocation outside the supervisory session needed for preparation should also occur.

In this principle, the group positioned the supervisee at the core of clinical supervision. The principle suggests ways of sharing this responsibility between the supervisee and the supervisor. The supervisor would set the scene for the supervisee about what to expect and direct efforts towards understanding the supervisee’s individual learning requirements. The supervisee would need to reflect on their own learning needs and make appropriate preparations for each session.

Participation Principle 5: Good supervisory relationships

The supervisory relationship should reflect aspects of trust, reliability, approachability and honesty, be non-judgemental and foster open communication.

Implementation Guidelines

Clinical supervision should occur within a safe environment, both physically and interpersonally, to enhance trust, in an attempt to promote openness and confidence within the supervisory relationship.
Adequate supervisor training and supervisee input into supervisor allocation should also be considered. Should problems occur within the supervisory relationship, either the supervisee or supervisor should contact the senior staff member designated on the supervisory contract/agreement, who will consider the issue in relation to:

1. The specific issue raised
2. The length of time spent within the supervisory relationship
3. Attempts to repair the relationship

Where a supervisee is concerned regarding the supervision relationship because of:

1. Unethical procedures
2. Unworkable relationship
3. Incompatibility of working models
4. Supervisor’s failure to honour the supervision contract/agreement (for example, time available)
5. Other,

The procedures below will be followed in the order in which they appear:

a. Where possible, the supervisee should discuss the matter of concern with the supervisor.

b. The matter is discussed with the appropriate senior.

c. Where appropriate, the senior discusses the matter with the supervisor and attempts to resolve the issue. The senior documents the resolutions and copies are given to each party. In this case provision for review of the situation is made in three months, at which time the senior will conduct an interview with each party separately.

d. In cases where resolution is not possible, the supervision relationship will be terminated and the senior will assist in the arrangement of alternative supervision. Notification of termination of supervision will be given to the supervisee’s line manager.

e. In cases where there have been breaches of professional ethics or codes of conduct by the supervisor or supervisee, the senior will follow appropriate professional procedures.

The importance of good supervisory relationships is reflected in the time participants spent addressing each of the issues within this principle. The principle begins with a focus on the trust and safety necessary for a successful supervisory relationship. There is considerable attention given
to practical steps for both supervisees and supervisors, should problems arise within the relationship. The groups identified that there was a power disparity for the supervisee that might result in an avoidance of addressing the problems. Clearly stated procedures were identified as a way to bridge this power gap and facilitate early conversations should problems arise. Clear procedures for supervisors were also proposed, and were based on participants’ experiences with problematic supervisory relationships and a lack of knowledge in managing them. The suggested processes also establish clear boundaries about when outside advice should be sought.

**Participation Principle 6: Feedback**

*Feedback should occur regularly. Feedback should be a two-way process and specific systems for supervisee to supervisor feedback should be in place. Feedback should be constructive, with the aim of supporting supervisee learning, critical thinking and problem-solving.*

**Implementation Guidelines**

**Supervisees:** To address issues of perceived power imbalance, a feedback form might be used to facilitate feedback to the supervisor from the supervisee; this should be given to the supervisee at the commencement of each supervisory contract/agreement. This might include boxes to check and examples of positive and negative clinical supervision, and should occur every three to six months and at the end of each contract/agreement period.

**Supervisors:** Supervisors will present this feedback and their own responses to feedback to their own (the supervisor’s) supervisor for reflection. An opportunity for feedback to the supervisee should occur at every supervisory session. Feedback, which is important for learning, should be for the supervisee and supervisor. Feedback to the supervisee should be constructive and not negative.

Participants considered feedback within and about clinical supervision as essential to improving the quality of supervision. Discussion often centred upon the difficulties of giving and receiving feedback and the corresponding need to be explicit about the ways in which it should be given and to whom. Of particular interest was the structuring of feedback to the supervisor. Participants acknowledged that supervisees might be reluctant to give face-to-face feedback to supervisors in the existence of possible power disparity. Participants also acknowledged that giving
feedback was an important skill to learn. Differences of opinion occurred about whether feedback should be face to face or anonymous, with the former potentially resulting in less honest feedback and the latter, too harsh. The result was the production of a template for giving feedback from supervisees to supervisors (Appendix 3d). The decision about whether this feedback occurred face to face, anonymously or through a third party was a decision that could be negotiated within professions, departments or supervisory relationships.

Participation Principle 7: Documentation

Documentation includes any record of the supervisory session as well as contract/agreements made between supervisor and supervisee and supervisor reports. Specific professional and organisational requirements for documentation should be made clear, and a standard procedure for documentation adopted, which should not be value-laden or subjective. This should not override professional and legal requirements. Staff should be aware under what circumstances documentation may be released from the confidentiality of the supervisory relationship and the expectations around storage of documentation. Documentation should concern learning, obstacles to learning, facilitators of learning and goals for learning.

Implementation Guidelines

Documentation should be agreed and written into a contract/agreement template. Documentation expectations should be clear in terms of locked or secure electronic storage of the documentation; with whom the responsibility lies for creating the document; and what information is contained within the document. Storage time should be consistent with organisational requirements.

A list of minimum standards for documentation might be used in place of a template, such as:

1. Broad subject topic
2. Minimal identification of staff or clients (MRN might be used where appropriate)
3. Clear review of set goals and objectives
4. A focus on and around achievement of clinical goals and facilitators or barriers to these
5. The date that the clinical supervision occurred
6. A copy provided to both supervisor and supervisee, within seven days of the supervision occurring (this may be a paper or electronic record)

7. Confirmation of documentation's for accuracy prior to commencement of the next session on review of clinical supervision record with any comments or additions

8. Changes in practice/application of knowledge

9. A log of hours attended

Group discussion about documentation included issues such as: who owns clinical supervision documents, who writes them, where they are stored and when and for what other purposes they can be used. The process of decision-making integrated information from the academic literature, clinical-governance advice from within the health organisation and lengthy discussions about how to address some of the issues raised. The health organisation was clear that if the clinical supervision occurred within work hours, the organisation owned the documentation. The health organisation also discussed the possibility, albeit remote, that clinical-supervision documentation could be called upon in a legal investigation. This clarification resulted in participants deciding on a set of minimum standards for documentation (Appendix 3b). The developed format could record essential information from session to session, whilst complying with a minimum set of documentation points. Opposition to allocating the supervisor as the person making the documentation was resolved by allowing this decision to be made when creating the clinical-supervision contract. A requirement for a copy of clinical-supervision notes to be provided to both parties resolved the issue of accurate content and storage of documentation.

Participation Principle 8: Confidentiality

Requirements for maintaining the confidentiality of supervisory sessions are integral to the supervisor-supervisee relationship as well as a point of accountability for both. Such requirements should be made clear within the training accessed by all staff. Where a specific client is discussed or notes reviewed, minimal identifying information should be documented; MRNs and/or client initials might be used, where re-identification of a client might be required at a later time.
Implementation Guidelines

Confidentiality is a two-way process and should be seen as paramount to the maintenance of trust in a good supervisory relationship. Clear discussion should occur about when it might be appropriate to consult the supervisee’s line manager in relation to:

- Concerns for the supervisee’s progression
- Level of participation
- Concerning and ongoing gaps in knowledge

Such communication should only occur following:

1. Open communication with the supervisee and attempts to address the identified issues. This might occur as a review of appropriate goals, and the supervisee lead the consideration of strategies.
2. A set time frame for achievement and review.

Performance management issues should thus be directed to the appropriate senior for management. All discussions concerning the supervisee should also remain highly confidential.

Confidentiality was considered across the groups as essential to engendering trust within the supervisory relationship. Experiences where this trust had been broken indicated the likely inability to subsequently repair the relationship. Thus the groups outlined the responsibilities of maintaining confidentiality within the relationships. Concern about the supervisee’s performance within clinical supervision are examples when outside advice could be sought; however, communication with the supervisee was set as the first point of resolution.

Participation Principle 9: Learning

Learning should be at the centre of supervision. Adult learning principles should be core to all supervision activities and facilitate a commitment to ongoing learning and practice based in evidence.

Implementation Guidelines

Learning should be centred on the supervisee’s goals, which should be reviewed monthly. The supervisee is responsible for their own learning, and the supervisor is responsible for facilitation of that learning, by providing opportunities for enhancing learning. Adult-
Learning requirements and learning styles should be adapted to each individual.

Examples of learning opportunities might include:

- Demonstration of specific techniques
- Learning about specific conditions
- Hands-on demonstrations
- District-based learning opportunities or activities
- Discussion about resources or resource location
- Reading on specific clinical issues (e.g. journal article)
- Learning and teaching skills
- Identification of gaps in knowledge or skills
- Review of documentation
- Discussion of complex cases
- Case studies

A focus on supervisee learning was another way that participants placed the supervisee at the centre of clinical supervision. Responsibility for learning was described for both the supervisee and supervisor. Supervisees would be expected to set and meet learning goals to facilitate an individualised approach to their learning. The groups suggested several types of activities to facilitate learning in recognition of adult-learning principles and individual learning preferences.

**Key supervision requirements**

The principles of clinical supervision stand as the key requirements the set by participants. The descriptions that follow the principles tell the policy user what clinical supervision should look like. The implementation guidelines suggest practical ways to achieve this. These elements make the policy a self-explanatory document, incorporating and addressing the issues, questions and requirements of allied-health professionals. The experiences of the participants shaped their need for specific content. The participants’ intention for the policy was a comprehensive explanation of
how to achieve effective clinical supervision; this influenced the form and sequence of the policy. Thus the policy became the practical embodiment of participants’ own clinical supervision-experiences and the sum of their collective new knowledge.

5.3 Chapter Summary

The clinical-supervision policy presented in this chapter exemplifies the work that occurred across the action-research groups. Integrating the needs of the participants into a health organisation’s standard policy template was challenging; however, both the organisation and the participants facilitated each other’s needs in achieving the goal of a policy that was both relevant and complete. This ability to work together to achieve an outcome produced a policy that was more easily enacted and supported by both allied-health professionals and the health organisation. The relevance of the policy was derived from the process of development—action research groups—where allied-health participants were able to build a policy to meet their specific needs. The policy was complete because it included implementation knowledge as full explanation and clarification for all principles. Thus the achievement of the policy was in sharing, clarifying and explaining allied-health needs for clinical supervision and realising a structure that facilitated them.
### 5.4 THE CLINICAL SUPERVISION POLICY DOCUMENT

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<th><strong>NAME OF DOCUMENT</strong></th>
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<td><strong>EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR</strong></td>
<td>ISLHD Director of Operations and Extended Care</td>
</tr>
<tr>
<td><strong>AUTHOR</strong></td>
<td>Sue Fitzpatrick – Speech Pathology Head of Department, ISLHD</td>
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<tr>
<td><strong>KEY TERMS</strong></td>
<td>Clinical Supervision Principles of Supervision</td>
</tr>
<tr>
<td><strong>SUMMARY</strong></td>
<td>This document outlines the framework for provision of and participation in clinical supervision for Allied Health staff of ISLHD.</td>
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1. POLICY STATEMENT
All Allied Health staff are entitled to, and will receive clinical supervision.

2. AIM
To provide regular, consistent, high quality clinical supervision to all Allied Health staff which will:

- **Enhance** clinical skills;
- **Enrich** knowledge and best practice; and
- **Encourage** clinical development and provide feedback and support around this to further develop clinical skills. This will ensure provision of an up to date and evidence based service for all clients.

3. TARGET AUDIENCE
All allied health staff within each facility within the ISLHD.

4. RESPONSIBILITIES
**Allied Health Heads of Department** – to ensure that 100% compliance with the policy is observed (including training of supervisors) and that reporting of compliance is completed every 6 months to the appointed allied health executive.

**Supervising staff** – To ensure that all aspects of the policy are adhered to and that time commitments to supervisees are as per policy.

**Supervisees** – To participate in clinical supervision activities 1 hour every calendar month (as per 7.1.2).

The District Executive will support Allied Health Heads of Department in ensuring that:

- All allied health staff have access to clinical supervision
- All supervisors attend training before commencing supervision of staff
- Documentation of a contract/agreement occurs for every supervisee
- Minimum standards of documentation observed
- The District retains ownership of supervision notes via the supervisor
- Attendance and participation occurs
- That training is provided at regular intervals
5. DEFINITIONS

Clinical Supervision

*Clinical supervision is;* an activity of professional support and learning which empowers individual practitioners to develop knowledge and competence, maintain responsibility for their own practice and optimise safety and quality of care in complex clinical situations. The process of clinical supervision involves knowledge sharing, education, guidance, a clinical focus, learning, encouraging clinical development and the provision of feedback and support.

*Clinical supervision is not;* punitive, negative, performance management, performance appraisal, just about competence or attendance at organisational meetings or a counselling session.

Supervisor - Any Allied Health professional staff member required in their position description to perform supervision.

Supervisee - Any Allied Health staff member who is receiving supervision.

Contract/agreement – A written formal agreement between each supervisor and supervisee, outlining the agreed conditions of supervision.

6. DOCUMENTATION

(a) Allied Health Contract/agreement for Clinical Supervision
(b) Allied Health Clinical Supervision Minimum Standards for Documentation
(c) Allied Health Clinical Supervision – Supervisor Feedback Form

7. PRINCIPLES FOR PROVISION OF CLINICAL SUPERVISION

7.1 The District is committed to three principles in the provision of clinical supervision for allied health staff;

7.1.1 *Provision Principle 1: Training and Education*

All staff performing a supervisory role have access to and are resourced to attend generic supervisory training.

Supervision training should include information on documentation standards, confidentiality, adult-learning principles, feedback systems, organisational principles, guidelines and policy in relation to clinical supervision and rights and responsibilities. Supervisees should also receive information and education in relation to supervisee and supervisor
expectations. This should occur as part of the local departmental orientation process. Discipline-specific training may also require compliance in accordance with professional associations and standards.

**Implementation Guidelines**
Any staff providing clinical supervision should have access to the minimum training requirement. This would be seen as a one-off requirement; however, it should not preclude access to further supervisory training. Requirements to provide clinical supervision would be outlined within position descriptions and would be mandatory for those staff. Departmental support for release of these staff is essential.

Suggested inclusions for training are:
1. What is clinical supervision?
2. How do you do it?
3. What are the requirements or mandates of the organisation’s policies in relation to clinical supervision?
4. Vignettes and examples
5. Role plays
6. Managing challenges
7. Allocation of supervisees and supervisors

**7.1.2 Provision Principle 2: Defining frequency and type of supervision**

A range of supervision options should be available to all staff.
As a minimum recommended standard, an hour of clinical supervision per month would be expected. This may include participation in any other supervisory activities, and individual learning needs would be considered when negotiating required time. Access to supervision via teleconference and videoconference should also be considered. Supervision might occur in both inter- and intra-disciplinary capacities. The stated frequency and type of supervision would not override specific professional requirements, such as those mandated by National Registration Boards. One hour of one-to-one/individual clinical supervision each calendar month is the minimum recommended requirement. Requirements for types of supervision will be set by individual professions through a dedicated business rule. Part-time staff may discuss a pro-rata or modified time commitment with the appropriate senior staff member.

**Implementation Guidelines**
A range of clinical-supervision options should be available to all staff. Individual clinical supervision should be made available to staff, however, other types of clinical supervision, such as group, peer, ad-hoc telephone
calls should be considered and may also be in addition to this time, not in place of it. Paid external supervision might be considered where all internal options have been exhausted, at the discretion of the District Executive.

7.1.3 **Provision Principle 3: Transparency and Consistency**

Policy application and accessibility of supervision is transparent and consistent throughout all Allied Health Departments and to all Allied Health staff. This will ensure consistency of supervision during rotation or change of site.

**Implementation Guidelines**
- Clinical supervision dates, times and sites need to be set in advance and negotiated at the initiation of a contract/agreement.
- Session boundaries, such as switching off telephones and pagers etc., should be clear
- Re-bookings missed sessions should occur as soon as possible and should replace missed sessions, rather than waiting until the next scheduled session.
- A substitute supervisor should be arranged when the supervisor is on leave.
- There is an expectation of commitment from both supervisee and supervisor to put aside consistent time for clinical supervision.
- Templates or minimum standards are used by all staff

7.2 The District and Allied Health staff are committed to nine principles for participation in clinical supervision.

7.2.1 **Participation Principle 1: Support**

Provision of ongoing supported learning and support for the supervisee in the professional-personal interface. The principles of participation target the taking part or sharing in the clinical-supervision process.

**Implementation Guidelines**
There should be clarity around support boundaries. Contracts/agreements can be used to set clear boundaries around types of support that would be appropriate. Clinical supervision is not a counselling session; it has a focus on clinical work. Should any personal distress be identified or notified by the supervisee, the supervisee will be reminded of the
availability of the service provided by the Employee Assistance Program (EAP), who provide strictly confidential, free, professional counselling to all staff for a broad range of personal or work-related concerns such as stress-related problems and work issues.

7.2.2 Participation Principle 2: Accessibility

Access to supervision should occur regardless of experience, number of hours worked per week, geography or isolation, caseload or status in the organisation. Access should be regular and facilitated.

Implementation Guidelines
A variety of modalities for delivery of clinical supervision should be considered. These may include teleconferencing and videoconferencing. Communication with all line managers concerned regarding the agreements and commitments should occur. Times should be negotiated between all parties.

7.2.3 Participation Principle 3: Input into supervisor allocation

Consultation should occur with line managers and supervisees, and should consider service requirements. Consideration might be given to supervisor rotation. The skills of the supervisor and supervisee should be considered when allocation occurs.

Implementation Guidelines
- This should always occur in consultation with the supervisee, supervisor, line managers and service requirements.
- A commitment to good supervisory relationships may require input into supervisor allocation.
- Difficulties with allocation may occur; this may require negotiation with all parties concerned.
- All efforts should be made to allocate a supervisor who is not the direct line manager of the supervisee.
- Where this is not possible, separation of clinical and non-clinical supervision is paramount, and regular assessment of the success of the relationship should occur.
- Attempts should be made to match the area of expertise and appropriate level of clinical knowledge.

7.2.4 Participation Principle 4: Supervisee-centred
Consideration should be given to supervise learning style, be aimed at supervisees learning and be based around issues brought to supervision by the supervisee. To this end, the supervisee should come to supervision with adequate preparation. Supervision should occur within a negotiated, safe, comfortable environment.

**Implementation Guidelines**

- **Supervisee’s learning styles and previous supervisory experiences should be identified.**
- **Supervisee should be provided with an information sheet, instructing them how to prepare for a clinical-supervision session.**
- **A contract/agreement template should be used to negotiate agreements, including aspects such as time, frequency, site and boundaries.**
- **Supervisees should bring clinical cases or clinical topics/issues to the session for discussion.**
- **Goal-setting should occur with the supervisee.**
- **Clarity around time allocation outside the supervisory session needed for preparation should also occur.**

7.2.5 **Participation Principle 5: Good supervisory relationships**

The supervisory relationship should reflect aspects of trust, reliability, approachability and honesty, be non-judgmental and foster open communication.

**Implementation Guidelines**

*Clinical supervision should occur within a safe environment both physically and interpersonally to enhance trust, in an attempt to promote openness and confidence within the supervisory relationship.***

Adequate supervisor training and supervisee input into supervisor allocation should also be considered. Should problems occur within the supervisory relationship, either the supervisee or supervisor should contact the senior staff member designated on the supervisory contract/agreement, who will consider the issue in relation to:

1. The specific issue raised
2. The length of time spent within the supervisory relationship
3. Attempts to repair the relationship

**Where a supervisee is concerned regarding the supervision relationship because of:**

a. Unethical procedures
b. Unworkable relationship  
c. Incompatibility of working models  
d. Supervisor’s failure to honour the supervision contract/agreement (for example, time available)  
e. Other,  

The procedures below will be followed in the order in which they appear:  
a. Where possible, the supervisee should discuss the matter of concern with the supervisor.  
b. The matter is discussed with the appropriate senior.  
c. Where appropriate, the senior discusses the matter with the supervisor and attempts to resolve the issue. The senior documents the resolutions and copies are given to each party. In this case provision for review of the situation is made in three months, at which time the senior will conduct an interview with each party separately.  
d. In cases where resolution is not possible, the supervision relationship will be terminated and the senior will assist in the arrangement of alternative supervision. Notification of termination of supervision will be given to the supervisee’s line manager.  
e. In cases where there have been breaches of professional ethics or codes of conduct by the supervisor or supervisee, the senior will follow appropriate professional procedures.  

7.2.6 Participation Principle 6: Feedback  
Feedback should occur regularly. Feedback should be a two-way process and specific systems for supervisee to supervisor feedback should be in place. Feedback should be constructive, with the aim to support supervisee learning, critical thinking and problem-solving.  

Implementation Guidelines  
Supervisees: To address issues of perceived power imbalance, a feedback form might be used to facilitate feedback to the supervisor from the supervisee; this should be given to the supervisee at the commencement of each supervisory contract/agreement. This might include boxes to check and examples of positive and negative clinical supervision and should occur every three to six months and at the end of each contract/agreement period.  

Supervisors: Supervisors will present this feedback and their own responses to feedback to their own (the supervisor’s) supervisor for reflection. An opportunity for feedback to the supervisee should occur at every supervisory session. Feedback, which is important for learning,
should be for the supervisee and supervisor. Feedback to the supervisee should be constructive and not negative.

7.2.7 Participation Principle 7: Documentation

Documentation includes any record of the supervisory session as well as contract/agreements made between supervisor and supervisee and supervisor reports. Specific professional and organisational requirements for documentation should be made clear, and a standard procedure for documentation adopted, which should not be value-laden or subjective. This should not override professional and legal requirements. Staff should be aware under what circumstances documentation may be released from the confidentiality of the supervisory relationship and the expectations around storage of documentation. Documentation should concern learning, obstacles to learning, facilitators of learning and goals for learning.

Implementation Guidelines

Documentation should be agreed and written into a contract/agreement template. Documentation expectations should be clear in terms of locked or secure electronic storage of the documentation; with whom the responsibility lies for creating the document and what information is contained within the document. Storage time should be consistent with organisational requirements.

A list of minimum standards for documentation might be used in place of a template, such as:

1. Broad subject topic
2. Minimal identification of staff or clients (MRN might be used where appropriate)
3. Clear review of set goals and objectives
4. A focus on and around achievement of clinical goals and facilitators or barriers to these
5. The date that the clinical supervision occurred
6. A copy provided to both supervisor and supervisee, within seven days of the supervision occurring (this may be a paper or electronic record)
7. Documentation should be confirmed for accuracy prior to commencement of next session on review of clinical supervision record with any comments or additions
8. Changes in practice/application of knowledge
9. A log of hours attended

7.2.8 Participation Principle 8: Confidentiality
Requirements for maintaining the confidentiality of supervisory sessions are integral to the supervisor-supervisee relationship as well as a point of accountability for both. Such requirements should be made clear within the training accessed by all staff. Where a specific client is discussed or notes reviewed, minimal identifying information should be documented; MRNs and/or client initials might be used, where re-identification of a client might be required at a later time.

**Implementation Guidelines**

Confidentiality is a two-way process and should be seen as paramount to the maintenance of trust in a good supervisory relationship. Clear discussion should occur about when it might be appropriate to consult the supervisee’s line manager in relation to:

- Concerns for the supervisee’s progression
- Level of participation
- Concerning and ongoing gaps in knowledge

Such communication should only occur following:

1. **Open communication with the supervisee and attempts to address the identified issues**. This might occur as a review of appropriate goals, and the supervisee lead the consideration of strategies.
2. **A set time frame for achievement and review**. Performance management issues should thus be directed to the appropriate senior for management. All discussions concerning the supervisee should also remain highly confidential.

### 7.2.9 Participation Principle 9: Learning

Learning should be at the centre of supervision. Adult learning principles should be core to all supervision activities and facilitate a commitment to ongoing learning and practice based in evidence.

**Implementation Guidelines**

Learning should be centred on the supervisee’s goals, which should be reviewed monthly. The supervisee is responsible for their own learning and the supervisor is responsible for facilitation of that learning by providing opportunities for enhancing learning. Adult-learning requirements and learning styles should be adapted to each individual. Examples of learning opportunities might include:

- Demonstration of specific techniques
- Learning about specific conditions
- Hands-on demonstrations
- District-based learning opportunities or activities
Discussion about resources or resource location
Reading on specific clinical issues (e.g. journal article)
Learning and teaching skills
Identification of gaps in knowledge or skills
Review of documentation
Discussion of complex cases
Case studies

8. REFERENCES


5.5 CLINICAL SUPERVISION POLICY TEMPLATES
The four templates that were attached to the allied-health clinical-supervision policy are included here as exemplars of the requirements of the policy.

a) Allied-health contract for clinical supervision

b) Allied-health clinical supervision minimum standards for documentation

c) Documentation template – example

d) Allied-health clinical-supervision supervisor feedback form
ALLIED HEALTH CONTRACT FOR CLINICAL SUPERVISION

☐ I have read the ISLHD Allied Health Clinical Supervision Policy.

Signed: ___________________________ Date: ______________________

☒ ISLHD expects Allied Health clinicians to be supervised 1 hour each month individually as a minimum.
☒ The supervisor copy of this record remains the property of ISLHD. Records are to be retained for periods required by the ISLHD.

Agreement between:
Supervisee: ________________________ and
Supervisor: _________________________

Length of Contract: ___________________________ From: ___________ To: ___________

Agreements
Frequency

Length of sessions

Location

Recording/Documentation (who will document)

Storage of supervision record

Agreement for agenda

Content and focus of supervision should be based on:

• Learning goals and facilitators and barriers to this
• Reviewing your work via discussion, reports, observations
• Agreeing and monitoring actions
• Identifying your goals, interests and action plans
• Providing space for you to reflect upon your experience of the work
• Reviewing this agreement, including your feedback about the progression of supervision
Agreement for commitment

**Supervisee:**
- I agree to commit to the time required to attend and prepare for supervision
- I agree to come to each supervision session having prepared topics / issues / agenda beforehand
- I agree to take action to facilitate my learning between clinical supervision sessions

**Supervisor:**
- I agree to put aside regular and consistent time to supervise ______________________ (Supervisee)
- I agree to be a primary source of support for the duration of the contract
- I agree to provide learning opportunities for ______________________ (Supervisee)

**Agreement for co-contribution:**
What I want from you as my supervisor;

________________________________________________________________________

________________________________________________________________________

What I will contribute as the supervisee to make this work;

________________________________________________________________________

________________________________________________________________________

What I want from you as a supervisee;

________________________________________________________________________

________________________________________________________________________

What I will contribute as a supervisor to make this work;

________________________________________________________________________

________________________________________________________________________

What we will do if there are difficulties working together;

________________________________________________________________________

Who we can discuss these difficulties with;

________________________________________________________________________

☐ Supervisor Feedback form given to supervisee

Signed___________________________

Supervisee _______________________

Supervisor
ALLIED HEALTH CLINICAL SUPERVISION MINIMUM STANDARDS
FOR DOCUMENTATION

1) Broad subject topic

2) Problem/goal/action/outcome table

3) No identification of staff or clients

4) Clear review of set goals and objectives

5) Be focused on and around achievement of clinical goals and facilitators or barriers
to these

6) Have the date that the clinical supervision occurred

7) Should provide a copy to both supervisor and supervisee (this may be written or
as electronic record)

8) Documentation should be confirmed for accuracy prior to commencement of next
session or review of clinical supervision record with any comments or additions

9) Changes in practice/application of knowledge

10) A log of hours attended
Documentation Template – Example

Date: _______________________________

Supervisee: ______________________ Supervisor: ______________________

Current Caseload (where appropriate):

☐ Supervision notes reviewed from last session (for agreement).
   Comments on supervision notes:
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Review of goals and actions from last session:

1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________

Successes: __________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

Barriers: _____________________________________________________________
   ________________________________________________________________
   ________________________________________________________________

How has your practice changed or how have you applied that knowledge this month?

   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
   ________________________________________________________________
Topics discussed today:

- 
- 
- 
- 
- 

Goals for this month:
1. __________________________________________
2. __________________________________________
3. __________________________________________

**Actions.**
Supervisee:
1. __________________________________________
2. __________________________________________
3. __________________________________________

Supervisor:
1. __________________________________________
2. __________________________________________
3. __________________________________________

Month: ___________________________ No. of hours attended: _______________________

**Next Session:**
Date: ___________________________
Time: ___________________________
Place: ___________________________
# ALLIED HEALTH CLINICAL SUPERVISION - SUPERVISOR FEEDBACK FORM

**Supervisee:** ______________________  **Supervisor:** ______________________

**Date of Feedback:**
» Please submit this form to your supervisor every 3-6 months **and** at the end of the contractual period.

**Please feedback on your supervisor’s performance by rating how well they are meeting your current supervisory needs by marking if they meet all/some/few of your needs.**

<table>
<thead>
<tr>
<th>Few of My Needs</th>
<th>Meeting Some of My Needs</th>
<th>Meeting All of My Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

## 1. Structure of Supervision

- **Documentation**
  - Prompts: Regularly completed? Appropriate detail?

  **Comment:**
  
  ____________________________
  
  ____________________________
  
  ____________________________
  

- **Confidentiality**
  - Prompts: Do you feel safe with information shared? Are you discussing appropriate client information?

  **Comment:**
  
  ____________________________
  
  ____________________________
  
  ____________________________
  

- **Clarity of the supervision process**
  - Prompts: Are you clear on who is responsible for what? Have you discussed the supervision process?

  **Comment:**
  
  ____________________________
  
  ____________________________
  
  ____________________________
  
  ____________________________
3. **Supervision Quality**

   - **Environment**
   
   Prompts: Is the area quiet enough to discuss issues? Are you being interrupted by phone calls or pagers? Is it too hot/cold/impersonal?

   Comment:
   
   [Blank]

   [Blank]

   [Blank]

   - **Feedback Frequency**
   
   Prompts: Are you getting feedback on your performance at each session? Is the feedback helpful? Is the feedback constructive or do you feel it is negative?

   Comment:
   
   [Blank]

   [Blank]

   [Blank]

   - **Feedback Quality**
   
   Prompts: Is the feedback specific? Does it contain enough detail? Are you learning from the feedback?

   Comment:
   
   [Blank]

   [Blank]

   [Blank]

4. **Challenges to supervision occurring**

   - **Availability of time**
   
   Prompts: Do you feel you are imposing on your supervisor’s time? Are your sessions frequently cut short? Is your supervisor regularly on time for your sessions?

   Comment:
   
   [Blank]

   [Blank]

   [Blank]
CHAPTER 6: META-SYNTHESIS OF TEXTS FORMED A FOUNDATION FOR PRACTICE

6.1 Published Paper

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Clinical Supervision in Allied Health in Australia: A Model of Allied Health Clinical Supervision Based On Practitioner Experience

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Recommended Citation
Clinical Supervision in Allied Health in Australia: A Model of Allied Health Clinical Supervision Based On Practitioner Experience

Purpose: The purpose of this manuscript is to identify key elements of allied health clinical supervision based on allied health practitioner’s experiences. Method: This study was conducted with qualitative methodology, including content analysis, and draws on hermeneutic interpretation of texts. Data were collected through an online survey in an Australian health service and subsequent focus groups. Results: Findings revealed four key dimensions including accessibility of regular clinical supervision, relationships between the supervisor and supervisee, clarity about the purpose, and roles and a focus on meeting the supervisee’s needs; these dimensions were central to the allied health practitioner’s experience of successful clinical supervision. A model of clinical supervision is proposed that is based on these four identified key dimensions. This model could be used as a broad schema to achieve a successful clinical supervision experience in allied health. Conclusion: This study contributes to the growing body of clinical supervision research by specifically addressing allied health needs in clinical supervision and proposing a model for its implementation. The authors contribute to the discussion about clinical supervision and its implementation by addressing needs that relate specifically to allied health and by developing a deeper understanding of the clinical supervision experiences of allied health clinicians. This new understanding provides a foundation for clinician-focused supervision, policy development and implementation.

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Clinical Supervision in Allied Health in Australia: A Model of Allied Health Clinical Supervision Based On Practitioner Experience

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1. Charles Sturt University, Doctoral Student
2. Charles Sturt University, Associate Professor, Head of School
3. Charles Sturt University, Adjunct Senior Lecturer

Australia

ABSTRACT
Purpose: The purpose of this manuscript is to identify key elements of allied health clinical supervision based on allied health practitioner’s experiences. Method: This study was conducted with qualitative methodology, including content analysis, and draws on hermeneutic interpretation of texts. Data were collected through an online survey in an Australian health service and subsequent focus groups. Results: Findings revealed four key dimensions including accessibility of regular clinical supervision, relationships between the supervisor and supervisee, clarity about the purpose, and roles and a focus on meeting the supervisee’s needs; these dimensions were central to the allied health practitioner’s experience of successful clinical supervision. A model of clinical supervision is proposed that is based on these four identified key dimensions. This model could be used as a broad schema to achieve a successful clinical supervision experience in allied health. Conclusion: This study contributes to the growing body of clinical supervision research by specifically addressing allied health needs in clinical supervision and proposing a model for its implementation. The authors contribute to the discussion about clinical supervision and its implementation by addressing needs that relate specifically to allied health and by developing a deeper understanding of the clinical supervision experiences of allied health clinicians. This new understanding provides a foundation for clinician-focused supervision, policy development and implementation.

INTRODUCTION
The purpose of this manuscript is to identify factors that make clinical supervision successful from the point of view of allied health staff. The study described in this paper was part of a wider study of allied health clinical supervision which aimed to develop a guide for supervision policy development. Successful clinical supervision is defined for the purpose of this paper as the creation of conditions in the workplace that enable reflection on clinical practice, facilitate teaching and learning and provide a safeguard or protection for clients. More specifically, clinical supervision has been described as an essential component of professional development, which allows the supervisee to develop their competence, confidence, and clinical reasoning skills. When clinical supervision is delivered effectively, it can have a positive impact on the supervisee’s professional growth and development.

When considering the role of clinical supervision in allied health, it is important to recognize the unique context in which it occurs. Allied health professionals provide a wide range of services, including physical therapy, occupational therapy, speech pathology, social work, and more. Each discipline has its own set of competencies and standards that must be met to ensure the delivery of high-quality care. Clinical supervision is an essential component of this process, as it allows for the continuous improvement of practice and the development of professionals who are well-equipped to meet the needs of their clients.

In conclusion, clinical supervision is a critical component of professional practice in the allied health field. It is essential for the development and growth of supervisees, and for the provision of high-quality care to clients. Further research is needed to better understand the role of clinical supervision in allied health, and to develop effective models and strategies for its implementation.

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Clinical Supervision in Allied Health in Australia: A Model of Allied Health Clinical Supervision Based On Practitioner Experience

Previous studies of clinical supervision have identified four key dimensions: the presence of a successful supervisory relationship, accessible clinical supervision, clarity of expectations in clinical supervision, and supervision that focuses on meeting the needs of the supervisee, as important issues in clinical supervision in allied health, nursing and medicine (Table 1). These four dimensions have been described either together or in isolation; however, no integrated model of clinical supervision has emerged. The result is an incomplete understanding of the needs of staff supervising, or being supervised, in allied health that would adequately inform policy development. In a previous publication, the authors have published a review of the literature that summarized the existing supervision literature as lacking a clear understanding of what clinical supervision means to allied health and how it should be implemented.1

Table 1. Supervision Studies Examine Four Key Dimensions

<table>
<thead>
<tr>
<th>Author, Profession Studied</th>
<th>Accessibility</th>
<th>Relationships</th>
<th>Clarity</th>
<th>Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hall &amp; Cox (2009), physiotherapy</td>
<td></td>
<td></td>
<td>Purpose of supervision not clear</td>
<td></td>
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<tr>
<td>Sweeney, Webley, Treacher (2001), Occupational therapy</td>
<td>The need for support of support referred to</td>
<td>Lack of guidelines to direct the process</td>
<td>Outlines needs of supervisees in study</td>
<td></td>
</tr>
<tr>
<td>Kilminster &amp; Jolly (2000), allied health, nursing, medicine</td>
<td>Time</td>
<td>Important factor for effectiveness</td>
<td>Need for better structure &amp; content.</td>
<td></td>
</tr>
<tr>
<td>Barnball, White, Munch (2004), nursing, allied health</td>
<td>Time</td>
<td>Trust</td>
<td>Role clarity</td>
<td></td>
</tr>
<tr>
<td>Townend (2008), psychotherapy</td>
<td>Relationships important</td>
<td>Roles of supervisee and supervisor important</td>
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<tr>
<td>White &amp; Winstanley (2010), mental health nursing</td>
<td>Can be seen as additional time to work duties</td>
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<tr>
<td>Ross (2013), mental health clinicians</td>
<td>Time</td>
<td></td>
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<tr>
<td>Ladany, Mori, Mehr (2012), psychology</td>
<td>Important factor in successful supervision</td>
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<tr>
<td>Grant (2000), mental health nursing</td>
<td>Typical reasons for breakdown and interventions used</td>
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<td></td>
<td></td>
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<tr>
<td>Page, Shritzke, McLean (2008), psychology</td>
<td>Case formulation model clarifying content</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pearce, Phillips, Dawson, Leggatt (2013), nursing, allied health, medical</td>
<td>Diversity of content exists</td>
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Therefore the aims of this study were to:
1. Develop an understanding of the clinical supervision experiences of allied health clinicians, and
2. Provide a foundation on which to base clinician-focused supervision implementation and policy development.
METHODS
A qualitative research approach was used to explore and understand allied health clinicians’ experiences in clinical contexts. A qualitative approach uses open concepts rather than predetermined definitions, inferential understanding rather than measurement, an interpretive perspective for analysis of text, and detailed verbal descriptions rather than numerical representations. A qualitative approach allows for multiple perspectives and the ability to complete in-depth investigation, which in this instance, was detailed exploration of the experiences of clinical supervision. From the range of qualitative research approaches, this study drew on the methods and philosophies of hermeneutics. The nature of hermeneutics is to interpret, or make meaning of an experience that is shared with participants. The participants’ descriptions of the experience under investigation are collected as texts, and these texts are interpreted by the researcher to develop an in-depth understanding of the experience. The recognition of the history and views of the researcher are paramount in arriving at a new understanding of the experience being studied. Gadamer and Linge described this as “fusion of horizons,” whereby there is a joining of the meaning of the text and of the understanding of the researcher to reveal a new understanding. The principal researcher in this study was an allied health head of department, working within the health service. The role of the researcher in this study was both as text collector and interpreter. This was acknowledged throughout the study to minimize the effect that the researcher’s position would have on participants.

Ethics
Approval from Charles Sturt University Australia and Wollongong University Australia Research and Ethics Councils was sought and granted. Participants were reassured of their anonymity and were given opportunity for anonymous replies or feedback.

Participants
Purposive sampling was used in this study to achieve the specific aims of the research, which in this study was allied health staff who had experienced clinical supervision. All allied health clinicians, as defined by the New South Wales Health Service Health Professionals (State) Award (2007), who had experienced supervision, either as a supervisor or supervisee, and were current employees of the specified health service that was the location for the research were invited to participate. For the purpose of the study, the term supervisee was defined as any allied health practitioner who had received supervision in either a one-to-one or group situation and by a peer/peers or from a manager or more senior staff member. A supervisor was defined as any allied health practitioner who had provided supervision to another health professional in either a one-to-one or group situation and by a peer/peers or from a manager or more senior staff member. To ensure the reliability of the survey data collected, participants were able to identify themselves as either one or both roles. Both supervisors and supervisees were recruited so that supervision could be explored from both sides of the supervision dyad. Supervisors and supervisees who had a range of supervisory experience were invited to participate to include a range of experiences along the supervisory spectrum. Recruitment was by invitation via health service email that enabled the maximum number of staff to be contacted. Participants volunteered from a range of professions within allied health.

The participating health service in this study was one of eight within New South Wales, Australia, and encompassed metropolitan, outer metropolitan, regional, and rural locations. This site was chosen because it was anticipated that the results may have broad relevance to other Australian health services as the research crossed all geographical locations and health environments. The inclusion of only one area health service allowed for timely completion of the study, as the logistics of seeking consistent allied health representation within one area health service was more easily coordinated than using multiple services.

The views and history of the principal researcher are important for the methodology utilised in this study. The principal researcher was a doctoral student and a current head of an allied health department and performed the role of survey distributor, overseer of the research process, and data interpreter. The views of the principal researcher about clinical supervision were founded on extensive reading of the literature across multiple professions. The principal researcher believed that clinical supervision issues and policy could cross professional boundaries; however, she was open to any and all experiences and requirements in clinical supervision for allied health.

Text Construction
The term “text” can apply to the written word (including documents), conversations (including transcriptions), drawings, and transcripts. In this study, texts were generated from a survey that required in-depth written response to participants’ experiences of supervision. Participants also participated in action research group discussions. The action research groups were used to build on the survey findings in order to explain phenomena identified in the survey. It also contributed to data triangulation by using different methods to collect the data. This manuscript only reports on information and texts resulting from the survey. Further findings from the action research groups are to be published in a future paper by the authors.
Survey
Invitations were sent to the allied health population via an institutional email to participate in an online survey of their supervisory experiences. The anonymous survey was hosted by an external survey product, and as such, neither identified the participant individually nor health profession of the participant. Thus, the anonymity of participants was protected, as re-identification may have been possible given the researcher was employed with the health service.

There were a total of seven questions (Table 2). Two questions asked closed questions: participants were asked to state how many years of experience they had as health professionals and whether they had more experience as a supervisee or supervisor. Five other questions were more open-ended. One of these short open-ended questions asked participants to state what he or she considered to be the three most important factors to the process of supervision. Another question asked participants to provide a description of an experience with clinical supervision with enough detail that the situation, issues, and outcomes could be easily understood.

<table>
<thead>
<tr>
<th>Table 2. Survey Questions.</th>
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</table>

Text Interpretation
Philosophical hermeneutics was applied to this research using tools which included questions asked of the text and emerging from the text and the use of the hermeneutic circle. This text interpretation approach using hermeneutics encourages understanding that acknowledges pre-understandings, ideas, categories or theories the researcher brings to the interpretation and allows these conceptualizations to be integral to the horizon of the text itself. It is important to understand that this knowledge forms part of the interpretation of text within this study and is also an important part of the hermeneutic. The principal researcher immersed herself in the text and identified categories. From the categories, themes emerged that allowed interpretation of the text to a deeper level of abstraction. Van Manen described themes as a “simplification and a way of ‘capturing the phenomenon one tries to understand.’”

The texts were read multiple times by the principal researcher to ensure an overall sense of the whole key words from each response were underlined and these words used as initial codes or themes. Similar themes were then grouped into higher order headings or categories to reduce the number of categories. Elo and Kyngäs described this process as “abstraction.” This process of moving from the “part” of single words to the “whole” of sentences form the hermeneutic circle.

In one example, both accessibility and regularity, when described as being absent, were deemed to be threats or barriers to clinical supervision. The main category themes were presented to the groups with sample stories from the survey text and served as a scaffold for identifying essential inclusions for developing key principles for clinical supervision.

Following repeated engagement with the text, exemplar descriptions were constructed to illustrate archetypal in-depth and contextualized understandings of the participants’ experiences. These case stories were a combination of different participants’ experiences that exemplified the study’s themes. Elo and Kyngäs considered that constant engagement and checking and re-checking of themes helps to ensure that saturation of the text occurs. The repeating engagement with the text as an attempt to make sense of pieces of the text in the context of the meaning of the whole text was another example of the hermeneutic circle.31
Clinical Supervision in Allied Health in Australia: A Model of Allied Health Clinical Supervision Based On Practitioner Experience

This repeating dialogue with, and analysis of, the text was followed by critique, reiteration, and reanalysis. This process was consistent with a hermeneutic dialectic; that is, one that continually reconsidered a position or construction with a new construction or understanding. The hermeneutic process was thus dialogically a combination of the horizon of the researcher and the supervision experiences being studied which resulted in a coalesced understanding or horizon. This is the concept of a fusion of horizons or the formation of a new shared understanding of the experience being studied.

Questions asked of the text during analysis included: What is the overall experience of supervision: is it positive or negative? What is the participant doing and feeling? What is main message the participant is trying to convey? When identified categories did not fit with the main themes identified, or were applicable across more than one theme, further analysis was required of each story to describe the essence or core message from each description. Themes were established and re-established in an attempt to encompass all of the issues identified by the participants.

Quality of the Research Process

Creswell addresses quality criteria including credibility, or how accurate the findings represent the participant’s experience, auditability or the details in the steps in text analysis, and interpretation and fittingness or an ability for the reader to understand the process and findings and decide on its relevance to them and their practice. The following procedures, described by Creswell, were employed in this study to ensure the credibility of the findings: Triangulation was employed by collecting multiple text sources from the same population of allied health professionals. This was achieved by extracting themes from the survey with the understanding of the content from the focus groups, allowing the researcher to ensure the emerging themes were representative of the wider population. Prolonged engagement was the second procedure and was achieved through the primary researcher engaging with the text intensively over a 3-4 month period and then over 2 years using the written text as well as engaging with auditory recordings of focus group text. The third procedure was member checking. The action research groups were used to check the relevance and accuracy of the text from the survey; this ensured that the participants played an active role in shaping and refining the findings. The action research groups confirmed the accuracy of the survey text through their strong identification with the stories written by the survey participants. In the fourth instance, audit trails of the content analysis of the text from the survey illustrated the movement from text to themes; this ensures the findings and conclusions re supported by the text. Finally, a thick rich description permits an evaluation of the transferability of results. This can occur though a detailed description of the study setting or context and allows the reader to decide whether the study results transfer to other settings. Text saturation was achieved when the themes emerging across all survey text showed a strong consistency of ideas with minimal variability and where all text fitted well into the identified themes. This suggested to the researcher that no further text was needed and the text was considered to be at saturation.

RESULTS

The survey was completed by 113 of approximately 1350 allied health staff members. Thus a response rate of 8 %, which may have been low due to some employees not having access to the internet within the workplace. Participants varied in their years of clinical experience (see Table 2) and in types of experience in clinical supervision (see Table 3).

Table 2. Years of clinical experience.

<table>
<thead>
<tr>
<th>Years of Clinical Experience</th>
<th>% of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>10.6</td>
</tr>
<tr>
<td>2-4</td>
<td>15.0</td>
</tr>
<tr>
<td>5-9</td>
<td>24.8</td>
</tr>
<tr>
<td>10+</td>
<td>49.6</td>
</tr>
</tbody>
</table>

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Four main categories or themes emerged from the participants’ experiences as playing a significant role in clinical supervision.

1. Lack of access to consistent clinical supervision

Participants experienced access to clinical supervision as inconsistent. For example, participant 64 described difficulty accessing clinical supervision: “Since entering [the health service], I have not received professional clinical supervision… I believe that this is greatly needed and should be addressed.” Consistency and availability of supervision were also problems for participant 47: “Supervision for me on the whole 9 years has been ad hoc even though there was a departmental policy. More often than not supervision was cancelled.”

Many of the participants expressed the desire to receive clinical supervision as a feature of their everyday practice regardless of their years of experience, geographical location, or part-time status. Participant 65 explained that being both part-time and geographically separated from other campuses of the health service affected her access to supervision: “Difficulties with access geographically and timing as both of us were part-time”.

Some participants reported not receiving any clinical supervision. This absence featured in participant 35’s experience: “As a new graduate I had no formal supervision. I had some informal peer supervision from a colleague… there were many times as a new graduate where I was left to cover the hospital on my own with no support, even with as little as one-two months experience as an adult acute therapist.”

Participants described feeling lost or abandoned when supervision was absent or failed to meet their needs. Participant 82 reported having “NO supervision [original emphasis]” and that on her “first day on a job… [I was] left for 4 hours to treat 10 very sick babies,” communicating distress by this lack of support.

Availability of time for supervision affected participants’ access to supervision. Participants described the experience of difficulty putting aside their clients in order to make time to attend supervision, and supervisors also appeared to struggle to make the time to be regularly available for supervision. “I have frequently found supervision hard to coordinate due to other pressing work issues” (participant 16).

2. The supervisory relationship is critical

Relationships appeared to have a key influence on the experience of supervision. For participant 95, described success in supervision when her supervisor changed. “[I] got placed with a supervisor whom I didn’t interact with as effectively as other members of the department. I requested a change of supervisor. . . I felt I could communicate issues and cases more comfortably and get much more out of clinical supervision [with the new supervisor].” For stories in which clear negative or positive experiences were described, the success or failure of the key supervisory relationship was revealed to be at the core of these evaluations of these experiences.

The concept of relationship is important within the context of group supervision as well as one to one supervision. Participant 18 described how an experience of poor interpersonal interactions could be a hindrance to successful clinical supervision. Speaking about group supervision, she wrote “Dynamics and personality clashes were the issue… it’s important… to feel secure with the person/people involved.” Participants considered that it was essential to feel safe during the supervision session: “The most important aspect for me was trust and confidence in supervisor” (participant 100). Participant 58 described how the supervisory relationship broke down irreparably when she felt that her trust in her supervisor was violated: “When supervised, private
information was disclosed to another person without my permission, as a result all trust was lost in the supervisor and I requested that a new supervisor be appointed”.

3. Need for a shared understanding of clinical supervision

Participants had difficulty predicting what to expect form clinical supervision. There was a lack of shared, clear, and consistent understandings of what clinical supervision would include and how it should be structured. Subsequently, each person in the supervision relationship had different expectations about the purpose, process, and practice of supervision. There was clarity about who participated in clinical supervision, which largely included traditional dyads of a senior person partnered with a junior person. In some supervisory relationships, peers supervised each other and others occurred in groups. There was less clarity about what should happen in clinical supervision and how this should be actioned. Participants who experienced poor supervision recommended that clearer standards and guidelines for supervision were needed, and conversely, participants who had successful experiences of supervision attributed success to having well-developed supervision standards and guidelines.

Descriptions of what was included in or requested from clinical supervision focused either on clinical work and the needs of the client, or support and the need of the clinician. Participant 40’s story typified that a focus on clinical work was part of clinical supervision: “I saw my clinical supervisor who advised me how to correctly document the sessions and phone calls with the patient and preschool teacher in case it ever came up in court.” The approach to clinical focus in supervision varied and included case discussion, demonstrating specific techniques, sharing and discussing resources, and assessment of clinical competency. Participant 117 described being grateful for support provided in clinical supervision: “The main outcome from this was that I was provided with support and had a sounding board to voice my frustration at the situation.”

Management of a clinician’s performance within the context of supervision was also described; some participants had a positive learning experience and thus acceptance of performance management when included within supervision. “I learnt that performance management is a large component of supervising staff” (participant 60). However, Participant 92 perceived that including performance management as part of supervision distorted and damaged the supervisory relationship. “As a supervisor, I was asked to address some issues with a clinician I was supervising. These issues were related to administrative tasks, yet my role...was for clinical supervision. My manager had delegated the other duties to me to address as she had a poor working relationship with the clinician and acknowledged she wanted to avoid any further negative interaction. Thus I felt that clinical supervision had crossed the line into performance management, and I see them to be two very different things. Supervision was supposed to have been a confidential and ‘safe’ time for the clinician to discuss any issues with their clinical work. By introducing the performance management component, our supervision relationship was damaged, and the clinician stopped raising issues she was concerned about. I was seen as ‘management’ rather than as a ‘clinical supervisor’.”

How supervision occurred varied considerably. The level of formality included highly formally structured, regular, one-to-one supervision sessions and informal opportunities to have a discussion with a peer over coffee. Participant 47 experienced less formalized supervision: “What we call ‘on the run’ supervision has developed as a great way to get supervision from colleagues willing to listen over a cup of coffee.” In contrast, participant 54 experienced that “it was helpful having a guideline which outlined points for discussion and areas of performance.”

The presence of a predictable or facilitating structure was described as a positive aspect of supervision. Structure was considered to be especially helpful when it clarified the expectations for the supervisee: “It was helpful to have a guideline which outlined points for discussion and areas of performance” (participant 54). The absence of structure conversely created negative effects on the outcomes of supervision. For example, participant 57 stated, “My experience with my supervisor of choice, however, has not been very structured and sometimes I don’t know where I am going.” Participant 57 indicated a need for clearer goals to be part of her supervision experience. Participant 78 also highlighted the negative impact that a lack of structure can have on the outcome of the supervision session: “[There was] no formal structure or content for the mentoring program [therefore]...mentoring sessions were often less productive.” The participants request for a clear structure, clear understanding and agreement about the expectations of the session, as well as the outcome for clinical supervision was evident in the descriptions.

4. Supervisee needs should drive supervision

The supervisees’ needs within clinical supervision were most frequently described as reflection, support, confidence, and learning. The degree to which each need was included in the clinical supervision experiences predicted a positive or negative
experience. Supervision in which all needs were addressed was experienced more positively than those in which only one or sometimes no needs were considered.

Supervisees appreciated the opportunity for reflection during supervision; they valued the opportunity to think critically about clinical work. Participant 17 wrote: “I enjoy reassurance that I am making the right clinical and service delivery decisions... It opened my eyes about policy and procedures with difficult cases. I wish my supervisor would help me to think critically and acknowledge my opinion, rather than give me their opinion first.” Supervisors also valued the opportunity that supervision provided to engage in reflection: “As a supervisor I have found clinical supervision rewarding and aids critical thinking” (participant 77).

Support, in the form of being fully present and giving assistance and encouragement, was frequent in descriptions of successful supervision. “My supervisor was very supportive though and helped me through it all” (participant 54). “My first job involved terrific supervision... it was a supportive, nurturing environment that enabled me to build my confidence and skill level” (participant 75). Conversely, for participant 2, absence of support resulted in a dissatisfying supervision experience that left participant 2 feeling disappointed. “Through the course of discussing a case, [I] became emotionally upset, to the point where I was crying. I felt that my supervisor at this time felt that it was inappropriate in supervision, and on reflection, feel that she did not have the capacity to cope with managing the emotional issues that can sometimes come up throughout works as well as she was able to provide practical and/or theoretical guidance.”

Developing self-confidence in one’s own skills and abilities was regarded as an important goal for supervision. Lack of attention to developing confidence may result in negative experiences of supervision. “I observed a situation recently, where a supervisor did not discuss clinical and professional issues with the supervisee immediately as they developed... The staff member therefore had a very negative experience in their rotation and their confidence was low afterwards” (participant 60).

Learning was considered by the participants to be essential in supervision. Participant 1 described supervision as assisting in the acquisition of new skills and knowledge, as well as providing an opportunity to reflect: “...have grown tremendously as a clinician. I feel that a large part of this is to do with my experience with supervision... challenging to think in new ways... [It has been a] helpful way of expanding my knowledge about clinical supervision and procedures with difficult cases. I wish my supervisor would help me to think critically and acknowledge my opinion.” Participant 79 experienced clinical supervision that did not meet her learning needs and was therefore dissatisfying: “...did not feel I gained insight or knowledge from the supervision.”

In summary, the four key themes illustrate the issues that were experienced as being essential to a successful experience for the supervisee. Supervision was considered successful when supervisee needs directed the supervision process and content, when there was easy access to consistent supervision, a good working relationship existed, and clear expectations and understanding between supervisor and supervisee. These findings have been used to assist in the development of a model for clinical supervision for allied health.

**DISCUSSION**

This study contributed to a deeper understanding of the clinical supervision experiences of allied health clinicians by providing the perspectives of supervisors and supervisees. The most important finding includes the development of a model of clinical supervision on which to base clinician-focused supervision implementation and policy development.

Based on the above main findings and new understanding that emerged from the survey text, The Allied Health Key Dimensions Model was developed (see model in Figure1). In this model, the needs of the supervisee have been placed at the core of providing clinical supervision. The supervisee has been placed at the center of the model as the text revealed that the needs of the supervisee being met or not met predicted a positive or negative outcome for clinical supervision. When the supervisee is at the center of the supervision process, supervision is viewed within the context of the supervisee. This context drives a shared understanding of the content and process of supervision and subsequently the establishment of a successful relationship and supervision that is regularly accessible. In the public health context, having a shared understanding about what supervision is and how it can meet the supervisee’s needs precedes the supervisory relationship in a practical as well as theoretical sense. The text also illustrated that supervisee needs differ from person to person and clinical context to clinical context, which strengthens the need to clarify expectations of clinical supervision. A model which has the supervisees at the center allows the flexibility to use the model for all clinicians and clinical contexts.14,15

The three remaining dimensions build upon the solid foundation of the supervisees needs. Clarity has been positioned next, as
the need for a shared understanding about what happens in clinical supervision is clearly conveyed in the text. The many ways in which supervision can be misguided has been made explicit by participants. Supervisory relationships are positioned next; as the text suggests, a poor relationship can be a hindrance to successful clinical supervision, even where there is a shared understanding of how it should function. Accessibility has been placed in the surrounding circle, as the text strongly indicated that gaining consistent access to supervision was a barrier to the overall success of clinical supervision and must be addressed, as it would be problematic for all other dimensions to be in place if supervisees were unable to access clinical supervision consistently. It is proposed that when all dimensions are addressed, successful supervision is predicted. The model implies that providing effective supervision is not just about the people but about the governance and ability to have the needs of the supervisee met. To apply the model, each dimension ought to be considered in turn, starting from the needs of the supervisee and moving through the dimensions of clarity, relationships and accessibility.

At an organizational level, the model could be used to help establish a clinical supervision policy or procedure and implementation of clinical supervision. Based on the findings of the study, accessibility could be considered by assessing organizational support for time available for supervision. Supervisory relationships could be examined for adequate choice and availability of supervisors. The availability of organizational policy or guidelines could clarify the purpose and process of clinical supervision, and taking action to ensure the organization is familiar with the needs of the supervisee in terms of reflection, support, confidence, and learning and could support meeting those needs.

At a departmental level, the model could be used to firstly introduce the concept of clinical supervision as being supervisee-centered and about meeting their needs. The department leader would then arrange adequate training on the content of the organizational policy and expectations for clinical supervision. The department or professional group would ensure access to a range of clinical supervisors to optimize opportunities for positive supervisory relationships, and make arrangements around time and clinical caseload for consistent access to clinical supervision.

To use the model individually, each dimension should again be considered in turn. For example, starting from supervisee needs and moving outward: A discussion to attain clarity about the supervision would occur and include agreement about the standards, the expectations, and what topics and roles should be included and excluded. Next, the supervisor and supervisee would negotiate the boundaries and roles of the supervision including a discussion about who to involve, what should be discussed, and how the supervision should be implemented. A supervisory relationship would then begin, and a subsequent discussion would occur about the frequency of supervision and which times were most suitable for supervision.

It is the opinion of the authors that The Allied Health Key Dimensions Model can be used to evaluate and develop clinical supervision at an organizational, departmental, or individual level. The model provides a visual reminder about all the dimensions that ought to be considered when establishing and evaluating supervision, and that the needs of the supervisee should be at the core of the clinical supervision. Clinical supervision ought to be regularly evaluated using the model as a guide to ensure the supervision experience continues to work successfully. The key to the supervisee experiencing successful clinical supervision is not that supervision consists of a fixed point of achievement that is built and then abandoned, but rather that supervisor and supervisee must be active in continually checking the four foundations of supervision and regularly redefining the clinical supervision.

Figure 1. The Allied Health Key Dimensions Model

Most of the existing models for clinical supervision focus on implementation of supervision or the content of supervision in nursing and mental health contexts. For example models with a broad focus on implementation include Townend, who presented
a model for psychosocial practitioners as a broad and complex framework.12 Models that focus on aspects of the workplace or organisation that affect implementation of clinical supervision include Ginge and Buss, who proposed a model that accounts for the relationship between clinical supervision and its anticipated benefits and the influence of workplace factors.34 Lynch and Happell also present models for supervision implementation in nursing with considerable attention to opposing workplace and organizational culture forces.35-37 Several models focus on the content of clinical supervision: Brunero and Lamont developed a supervision implementation model for nursing supervision session content; Ross presented a cognitive therapy supervision model specifically for mental health practitioners, and Page et al focused on a psychology case formulation model within the supervision session.14,17,38

The Allied Health Key Dimensions Model differs from these existing models in that it addresses both implementation and content of supervision and it is designed specifically for allied health staff and it can be used to enhance and evaluate individual, organizational, and group supervision. Thus, the model builds on knowledge and understanding of supervision and applies it in a broad way so that it has universal relevance and it also addresses a previously missed area of supervision: that of supervision in the allied health disciplines.

Study Limitations
There are several limitations to this study. Firstly, although there were 113 participants in this study, the percentage who participated of the total number of the allied health population was low. The anonymous nature of the survey did not allow profession identification; however, the overall distribution on supervisors to supervisors and were evenly spread with slightly less supervisee only participants. There was a higher participation amongst more experienced practitioners and this may relate to the availability of the internet-based survey for some allied health. Further studies should ensure that all participants have access to workplace based internet as this may have been a barrier to participation and have direct access to reminder emails to confirm widespread delivery. The range of experiences both chronologically and experientially combined with the in-depth nature of the study provided increased representation in this context. Secondly, the text collection method of using an internet-based survey may have limited the richness of the text collected. Face to face groups followed the survey to ensure a more in-depth source of text informed the researcher and confirmed text collected from the survey. Thirdly, only staff from one health service participated. A more heterogeneous sample that included staff from other services may have yielded different understandings of allied health supervision. The aim of the study was not to generalize to all health service settings, but to describe the current supervision experience in the settings described in a way that can contribute to transferability to other settings.

CONCLUSION
Drawing on a study of the experience of supervision from the perspectives of supervisors and supervisees, the authors propose that in allied health, successful clinical supervision is achieved by attending to four inter-related factors: a clinician’s ready access to supervision; having a trusted and supportive supervisory relationship; being clear about what to expect from supervision and how it will be delivered; and receiving supervision that is focused on meeting the needs of the supervisee. The Allied Health Key Dimension’s model builds on understandings of supervision that were revealed through understanding the supervision experiences of allied health staff and which were also identified in previous research. The model has broad applicability even though it was specifically developed for allied health staff. The authors suggest that the Allied Health Key Dimension Model may be of assistance in establishing and monitoring supervision at individual, team, and organizational levels.

REFERENCES


6.2 A Reflection on the Paper

This chapter presents an example of a published paper as text, which reflects my understanding of my role as researcher and of the experience of clinical supervision at specific points in the research. The paper also captures my understanding and interpretation at a static point in time, which I recorded in my reflections on the research process. This first phase of the meta-interpretation process was instrumental in laying the groundwork for my further interpretation and fusion of horizons. The Allied Health Key Dimensions Model for clinical supervision was the first expression of the practical and theoretical components of this study. The model is a practical manifestation of a theoretical interpretation of clinical-supervision experiences.

This chapter demonstrates the way this study put into action the clinical-supervision needs that the participants identified. The significance of this study begins with the action-research process (Chapter 4) and continues to address broader and more complex needs within the meta-interpretation. The tools that developed from these actioned needs are thus practical, as they are based in the experiences of the allied-health professionals.

6.3 The Clinical Supervision Toolkit

In my study, I investigated action research as an approach to developing clinical supervision policy. I also developed The Allied Health Clinical Supervision Model of clinical supervision (Figure 6), which captures and explains the 4 key domains to consider, when evaluating or reviewing the current clinical supervision situation in a health organisation. Since the construction of The Allied Health Clinical Supervision Model (Figure 6), I have developed a more complex integration of the findings across the study. This integration was in the form of a further meta-interpretation, which was consistent with a hermeneutic methodology. The meta-interpretation method is described in detail in Chapter 2. In this section I will present the resulting conceptual framework as an outcome of the second meta-interpretation (Figure 7).
Conceptual frameworks are increasingly used as a means to translate clinical research knowledge into clinical practice (Hudon, Gervais, & Hunt, 2015; Jabareen, 2009; D. Smith, 2015). It was appropriate to consider a conceptual framework as a way of translating the new knowledge from my study into an easily understood structure. The conceptual framework functioned as an “overarching representation of key elements” which could acknowledge the process, context and key dimensions required for understanding and implementation (Hudon et al., 2015, p. 631).
I chose to present the conceptual framework in the form of a toolkit, and labeled it The Clinical Supervision Toolkit (Figure 7). I decided to use a toolkit as a metaphor because it is “a personal set of resources” (Oxforddictionaries.com, 2016) and “a set of all the parts needed to assemble an item” (Australian Concise Oxford Dictionary 5th Ed, 2009, p. 782). Thus my aim for The Clinical Supervision Toolkit (Figure 7) was first, to explain the elements and concepts that constitute clinical supervision and second, to act as a resource for understanding how the parts create a whole meaning of allied health clinical supervision. I developed the concept of toolkit as it was a visually accessible way to encapsulate each of the tools and outcomes from my study, into one straightforward representation. The Clinical Supervision Toolkit (Figure 7) was based within the experiences of allied health clinicians and provided
the opportunity to explain allied health clinical supervision and implementation, as not only practical tasks but as a broader set of concepts.

I chose a circular form for The Clinical Supervision Toolkit (Figure 7), as it integrates the outcomes from the study through intersecting circles. Circles also represent a non-linear approach to clinical supervision and communicate a continuity in understanding and developing clinical supervision practice. The circle is also consistent with the repeating action research cycles and the ongoing nature of generating new hermeneutic horizons.

The Clinical Supervision Toolkit (Figure 7) is also consistent with the hermeneutic circle as it demonstrates the many parts of: The Allied Health Clinical Supervision Model (Figure 6), reflection, people, practice and structure, to the whole understanding of clinical supervision in allied health. Next I will provide a general description of the structure of The Clinical Supervision Toolkit (Figure 7) and its elements followed by a detailed individual description of each element.

At the centre of The Clinical Supervision Toolkit (Figure 7), is The Allied Health Key Dimensions Model of clinical supervision (Figure 6), which is presented in Section 6.2 in this chapter, as a mechanism for understanding what is required to approach clinical supervision in a health organisation. There are three further key components of The Clinical Supervision Toolkit (Figure 7) which are important to understanding clinical supervision in allied health: reflection, people and practice. These three components intersect with The Allied Health Clinical Supervision Model (Figure 6), to encourage a connection between an active process of examining current clinical supervision practice, to the exploration of broader key clinical supervision concepts, to generate potential and new clinical supervision ideas. The action research clinical supervision policy development process, is represented by a circular arrow which moves through each of the three key components of The Clinical Supervision Toolkit (Figure 7): Reflection, People and Practice. The arrow ensures engagement with each of the three components in a continual and active process.
The Allied Health Clinical Supervision Model (Figure 7) is described in this chapter (6.2), as a tool to facilitate discussion and decisions in the evaluation of, and planning for, allied health clinical supervision, and is placed in the centre of The Clinical Supervision Toolkit (Figure 7) as a key clinical supervision resource. The four domains from The Allied Health Clinical Supervision Model (Figure 6): Needs, Clarity, Relationships and Accessibility are presented in the centre of The Clinical Supervision Toolkit (Figure 7). This central placement connects to the clinical supervision experience of the allied health professional, clarifying what is required and important to a successful clinical supervision experience. The Allied Health Clinical Supervision Model (Figure 6) interacts with all three key components of The Clinical Supervision Toolkit (Figure 7), to demonstrate the importance of moving between the guided questioning offered by the model, to broader conceptual considerations of reflection, people and practice.

Moving from the middle of The Clinical Supervision Toolkit (Figure 7) toward the outside, there are three key components required to understand clinical supervision in allied health: reflection, people and practice. These components emerged from an interpretation of the whole study and thus draw together the important considerations in understanding clinical supervision.

The components of The Clinical Supervision Toolkit (Figure 7) work together as a single framework to facilitate a conceptual understanding of allied health clinical supervision, and as a practical resource to understanding how to approach allied health clinical supervision development. Following is a detailed description of each component.

Reflection: The ability to look back at previous experience, practice and attitudes towards clinical supervision, was critical to the outcomes of this study. The action research process enabled thinking and reflection about what allied health professionals considered ideal practice, and also the possibility of change. In my study, reflection provided opportunity to identify clinical supervision needs and enable a different way of thinking about clinical supervision policy, and policy
development. Reflection was part of the action research policy development process, through conversation and discussion, and was an outcome for the participants of the action research process (Chapter 4). Thus Reflection was strategically placed at the top of the circle to signify its importance as the commencement point of understanding clinical supervision, and as a prompt to consider what is, what should, and could be in allied health clinical supervision practice.

People: the people connected to allied health clinical supervision encompasses the clients who benefit from improved practice, and the participants in clinical supervision. The key participants in allied health clinical supervision are the health professionals and the health organisation. Both are key contributors to a shared understanding of clinical supervision. People are important to developing the goals and vision for a future clinical supervision practice.

Practice: clinical supervision is a practice which is focused on clinical work. My study aimed to understand and develop changes to allied health clinical supervision practice, through examining what past, current, helpful and unhelpful practice meant for the development of an ideal of clinical supervision. In my study, suggested practice emerged from reflection on ideas, which were considered in the context of the health professionals involved. In The Clinical Supervision Toolkit (Figure 7), the Practice component intersects with The Allied Health Clinical Supervision Model (Figure 6) as clinical supervision practice is a key focus of the model.

Action research: surrounding the three key components in the model in a perpetual arrow, is the Action research clinical supervision policy development process, which in this study, was a tool to facilitate change. The action research tool, provides an ongoing process for a focus on reflection, people and practice. Similar to the action research process used in this study (Chapter 4), the perpetual arrow demonstrates movement through a process of understanding clinical supervision, allowing for an evolution in understanding to occur, and an expectation that each point in the clinical supervision journey would differ, according to each situation and environment.
Structure: the Clinical Supervision Toolkit (Figure 7) is enclosed in a shape that provides the toolkit with structure. In chapter 1, I identified structure as an essential requirement to change allied health approach to clinical supervision. Structure is defined as “give structure to; organise; frame” (Australian Concise Oxford Dictionary 5th Ed, 2009, p. 1431). The toolkit as a conceptual framework gives a broad conceptual structure to the study, and organises the outcomes into a clinical supervision resource for health professionals to approach and understand clinical supervision. My study provided structured approaches to clinical supervision using an action research policy development process and a clinical supervision policy, which structured the needs of the allied health professionals. The development of The Allied Health Clinical Supervision Model (Figure 6), structured an approach to allied health clinical supervision. Structure is essential to frame any approach to clinical supervision for allied health professionals and in health organisations to ensure consistency and agreement, as the changes to people and thinking lead to new practice.

The connection between each outcome in the study is presented in the Research outcomes connections (Table 3). The outcomes from experiential texts are placed in columns in an order that matches the chronology of the study. Beginning with the action research policy development process (Chapter 4), followed by, the policy principles which were developed from the action research process (Chapter 5), next, The Allied Health Clinical Supervision Model (Chapter 6, Figure 6) resulting from the first meta-interpretation, and finally, the four components of The Clinical Supervision Toolkit (Chapter 6, Figure 7).

The connections between the outcomes of my study are made across the rows of Research outcomes connections (Table 3). These connections begin on the left with the action research policy development process which present the outcomes for the group participants. When compared with the twelve clinical supervision principles (Chapter 5), the outcomes for participants align with the needs they had for clinical
supervision. The action research reflected outcomes for individual participants, the principles were hoped to apply to all allied health professionals.

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<th>Policy principles</th>
<th>Model</th>
<th>Concepts</th>
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<td>1 Learning</td>
<td>Supervisee-centred Support</td>
<td>Needs Relationships</td>
<td>People</td>
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<td>Input into supervisor allocation</td>
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<tr>
<td>3 Shared understanding</td>
<td>Documentation Feedback</td>
<td>Clarity</td>
<td>Practice</td>
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<td></td>
<td>Feedback</td>
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<tr>
<td>4 Problem-solving</td>
<td>Education &amp; training</td>
<td>Accessibility</td>
<td>Structure</td>
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<td>Support</td>
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<td>Defining frequency &amp; type of supervision</td>
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Table 3 – Connections among research outcomes

Moving right across column 1, the findings align to outcomes and which increasingly apply more broadly. The domains in the Allied Health Key Dimensions Model, apply broadly to an approach to clinical supervision, and broader still, the concepts emerging from the second meta-interpretation in The Clinical Supervision Toolkit. This movement from outcomes for individual participants, to increasing breadth of application is reflective of the conceptual work achieved through meta-interpretations, and moving from the practical space of action research to the theoretical space of a model and conceptual framework.

Row 1 introduces Learning which begins as an outcome for participants in the action research groups, creating new knowledge in both individuals and across groups. This new knowledge results in the policy principles which focus on the needs of the supervisee. Learning, appears frequently across the whole clinical supervision
policy, as a key goal, however, there is also a focus on the needs of the individual supervisee. The ability to have these needs met is reliant on the providers of the clinical supervision, that is, the supervisor and health organisation, which is why supervisor allocation and relationships is aligned with column 1, Learning. Moving to the right, the needs of the supervisee and relationship provide the link to meeting the requirements of the People involved in clinical supervision, which is the concept in the final column on the right. In this way there is movement from Learning as an individual outcome, to a broader recognition of all participants in clinical supervision to ensure its success.

Row 2 begins with Reflection which is a consistent theme throughout the study. Reflection is “an idea arising in the mind” (Australian Concise Oxford Dictionary 5th Ed, 2009, p. 1198), this concept of something that occurs inside the mind of the participant, reflects across the columns, this highlights the importance of deep thinking about clinical supervision and clarity of concepts.

Row 3 begins with a shared understanding, which was an identified gap in chapter 1. Whilst the policy principles give examples about specific aspects of clinical supervision that need to be clarified, the model names Clarity, as important which moves right to creating agreed practice as a concept in the final column. Shared understanding in row 3 was achieved through the development of the policy principles in a reciprocal way. The clarification of the policy principles across the action research cycles, established shared meaning and understanding across groups, and between participants. Documentation and Feedback in the policy principle columns are key examples of two principles that required extensive discussion to achieve a clarity of understanding. Thus Clarity as a domain of the Model in the third column captures the need for agreement and consistency across allied health professionals to achieve ideal Practice, which is capture with Practice as a concept in the next column.

Problem-solving in row 4, was the process undertaken to suggest practical solutions in the action research groups. The aligning policy principles include Accessibility,
Education and training, Support, Defining frequency and type of clinical supervision and were consistent with difficulties achieving these principles in participants’s clinical supervision practice. Accessibility is a key domain in the Allied Health Key Dimensions Model (Figure 6). Accessibility encapsulates the difficulty ensuring that these principles occur, because it was a lack of access to these principles that necessitated their inclusion as a principles. Thus moving right across the Research outcomes connections (Table 3) leads to the concept of Structure. To have access to the necessary elements of clinical supervision, requires a more permanent commitment from a health organisation and allied health professionals, structure can ensure this commitment. Research outcomes connections (Table 3) demonstrates that the research outcomes from my study, relate to each other in a practical and conceptual way, highlighting the value of both theoretical and practical understanding of clinical supervision in allied health.

The Clinical Supervision Toolkit (Figure 7) is the culmination of the outcome from my study. It coalesces the theoretical and practical elements of the study into a set of accessible resources, with which allied health professionals can develop and understanding of allied health clinical supervision. The Clinical Supervision Toolkit (Figure 7) aims to explain both, concepts important to allied health clinical supervision, and practical mechanisms important to approaching practice. The Clinical Supervision Toolkit (Figure 7), could thus be used as a resource. First, to establish a shared understanding about allied health clinical supervisor and agreement, second, to identify goals and gaps in current practice and finally, as a mechanism to act upon these in an agreed way.

6.4 Chapter Summary

In summarising this chapter, I reflect on the outcomes of the meta-interpretation. First, The Allied Health Key Dimensions Model of clinical supervision was presented in a peer reviewed published paper; a generated text that demonstrated the shift in my horizon and understanding about allied health clinical supervision (Figure 6).
Second the Clinical Supervision Toolkit was the final outcome of the meta-interpretation as an enactment of the findings throughout the study (Figure 7).

The Allied Health Key Dimensions Model of clinical supervision is the result of a hermeneutic interpretation of the cumulative texts, experiences and understanding throughout this study. The model emerged as a reflection of the interpreted experiences of the allied health participants and a practical tool for the evaluation and implementation of clinical supervision in allied health. This model contributes to the field of allied health clinical supervision as one that is broadly applicable across professions, addresses a gap in allied health specific clinical supervision models, and can be practically implemented all levels of clinical supervision participation.

The publication adds a new and practical model for allied health clinical supervision. This is a new way of evaluating clinical supervision and the model provides opportunities for individuals and organisations to evaluate and change their current practice using a needs-based model. It also focuses on allied health as a professional collective which is lacking in volume in the literature (Chapter 1).

The Clinical Supervision Toolkit illustrates the meta-interpretation process by abstracting the findings in Chapters 4 and 5 and the published text in Chapter 6, to a deeper level of understanding. I was led by the question “Is there any more to tell?”, and the answer emerged as the Clinical Supervision Toolkit. The toolkit provides a receptacle for the findings and outcomes of this study; more importantly, it makes them accessible to health professionals seeking a way to understand and enact them within the health workplace.
CHAPTER 7: DISCUSSION

7.1 Introduction

This chapter provides a statement of the main findings of this study in response to the aims: to understand the experiences and needs of allied-health professionals in clinical supervision, to investigate action research as a possible policy-development approach and to identify a framework within which the clinical-supervision needs of allied health could be met. In this chapter I discuss my approach to the development of a clinical-supervision policy and the practical application for clinical-supervision policy development and implementation, in the context of other authors’ work. The findings are then integrated and presented as a set of tools that can be used in the review and establishment of allied health clinical supervision. This chapter concludes with a reflection on the interpretation of the findings in this study and their significance in the context of the larger research landscape.

The format of this exegesis, which includes published papers as exegesis chapters, provided a discussion about the findings of the study within the context of each paper. Chapter 4 presented the findings of the clinical-supervision policy-development process as a submitted publication, which included a discussion about the meaning and implication of these findings. Likewise in Chapter 6, I discussed the presented results of the meta-interpretation in the context of a published paper which culminated in the introduction of the Clinical Supervision Key Dimensions Model. Following the paper in Chapter 6, I presented the findings from the second meta-interpretation, the Clinical Supervision Toolkit. To avoid repetition of the discussion points within Chapters 4 and 6, I will refer to each chapter for more in-depth discussion of specific concepts and literature.

This study has contributed to understanding clinical supervision in allied health and its practical implementation. The knowledge developed in this body of work addresses the gap in understanding about allied-health-specific clinical-supervision needs. This knowledge clarifies expectations and shared understanding of clinical
supervision, and advocates for structures to be established to guide effective supervision practice. Understanding allied-health experiences in clinical supervision was found to be an important basis for understanding the needs of allied-health professionals.

The outcomes of this study relate to the provision and creation of a practical and applicable clinical-supervision structure. Using action research to co-create clinical supervision policy provided the structure to respond to the clinical-supervision needs of the allied-health professionals. The development of the Allied Health Key Dimensions Model for clinical supervision (Figure 6) contributes to the field of clinical supervision and functions as a structure for clinical-supervision implementation. Finally, the products of the research – the policy-creation process and the Key Dimensions Model (Figure 6) – are set within a conceptual framework that provides a novel foundation from which to understand, evaluate and implement clinical supervision for allied health within a health environment.

The scope of this study did not extend to evaluating the implementation of the policy; however, the policy was implemented within the participating health organisation. The outcome of this implementation is discussed as a postscript section, following the conclusion chapter (Chapter 8), as while implementation of the policy was not within the scope of the study, it may be of interest to the reader.

7.2 Discussion of Main Findings

7.2.1 An understanding of the clinical experience of allied-health professionals

In this section I will discuss several authors who have examined clinical-supervision needs. In contrast, my study examined both the clinical-supervision needs of allied health and a process to respond to these needs within a policy. My study thus adds to existing knowledge by integrating needs and practical enactment of solutions.
My own understanding of the clinical-supervision experiences of study participants was an important step in the process of establishing relevant and successful clinical supervision for allied-health professionals. The sharing of past experiences created a shared understanding both amongst the participants and between the participants and myself. The clinical-supervision needs in allied health emerged from this shared understanding; these were expressed within the policy and later captured in the clinical-supervision tools. As a result of the meta-interpretation I identified four specific needs essential to allied-health participants in this study, which were expressed in the Allied Health Key Dimensions Model (Figure 6):

1. Clear expectations and understanding about what clinical supervision means and looks like as established between supervisor, supervisee and organisation.
2. Satisfactory supervisory relationships between supervisor and supervisee.
3. Consistently accessible clinical supervision.
4. Supervisee-centred clinical supervision that directs the supervision process and content.

Participants expressed their specific clinical-supervision needs as a set of 12 key principles, and included guidelines about how to meet these needs. The 12 principles are consistent with ideas about clinical supervision that were investigated before writing this chapter, but after the clinical-supervision policy-development process (Bush, 2005; Buus et al., 2013; Kuipers et al., 2013; Leggat et al., 2015; Redpath et al., 2015; Taylor, 2013). In the following three paragraphs I use three of the 12 principles to exemplify this consistency of needs across other authors’ research: accessibility, support and supervisee-centred clinical supervision.

Participants described accessibility as the need for regular access to clinical supervision, facilitated consistently throughout the organisation (Principle 5, 5.4). Accessibility of clinical supervision and health professionals’ available time to provide it is a barrier to effective clinical supervision (Kumar et al., 2015; O’Connell et al., 2013). O’Connell et al. (2013) studied nurses and midwives in an acute
hospital and emphasised available time as an important element in accessing clinical supervision. Finding time in a busy clinical schedule for clinical supervision is thus a shared element for all health professions. However, in my study, finding time for clinical supervision was not the only barrier to accessing it. Issues such as geographical location, part-time work and lack of manager support meant that the issue of accessibility had a much broader interpretation. This is reflected in the policy document and the inclusion of the many issues identified by participants as barriers to accessing clinical supervision (Chapter 5).

Participants stress the importance of support for learning and the professional-personal interface, describing them as the interplay between clinical experiences and emotional responses to these experiences (5.4). Several authors have highlighted the need for both professional and personal support in relation to clinical experiences and emphasised the role they have in the effectiveness of clinical supervision. Increased personal support improves the perceived effectiveness of clinical supervision (Dawson et al., 2012; Dawson et al., 2013). Sweeney, Webley and Treacher (2001b) examined the needs of occupational-therapy supervisees, finding that supervisees were unhappy with the quality of the emotional support given to them and were looking for opportunities to explore distress in an attempt to manage it successfully in the future. This same need was expressed within my study by participants as the “professional-personal interface” (Section 5.2). Participants recognised the need for support within clinical supervision and described what this support should look like, resulting in a focus on personal and professional support through the lens of client-related clinical work. The need to have clinical supervision based in the health professionals' clinical work is echoed by Redpath (2015) in her study of physiotherapy perspectives on clinical supervision. However, the participants in my study wanted to be clear that support in clinical supervision required boundaries to achieve such effectiveness.

Participants stated that supervisee-centred clinical supervision is aimed at facilitating supervisee learning with consideration to learning style, and is based around issues
brought to supervision by the supervisee (5.4). Participants added that supervisee preparation for clinical supervision ensures the focus of clinical supervision, and is based on the supervisee’s own clinical work and learning (5.4). Several authors have identified the importance of supervisee-led clinical supervision, particularly in determining the structure and content (Leggat et al., 2015; Redpath et al., 2015). In a study on physiotherapists, Redpath (2015) found that identifying supervisee learning needs and goals and allowing them to guide clinical supervision was perceived to be important. The centrality of the supervisee to the provision of clinical supervision thus focuses the process of meeting these needs. In my study, participants outlined the role and responsibilities of both supervisor and supervisee as a framework for how supervisee-focused clinical supervision could occur (5.4).

The remaining nine identified needs (5.4) from this current study are also consistent with those identified by other authors: *training and education* (Buus et al., 2013; Ellis et al., 2014; Howatson-Jones, 2003; Lynch & Happell, 2008a; Page, Stritzke, & McLean, 2008; Scott, Nolin, & Wilburn, 2006; Sloan & Grant, 2012); *transparency and consistency* (Barriball, 2004; Bush, 2005); *safe, high-quality, up-to-date and evidence-based service* (Fone, 2006; Hunter & Blair, 1999; Kuipers et al., 2013; Ross, 2013; Sloan & Grant, 2012); *input into supervisor allocation* (Edwards et al., 2005; Sloan & Grant, 2012; Weaver, 2001); *good supervisory relationships* (Barriball, 2004; Grant, 2007; Kilminster & Jolly, 2000; Ladany, Mori, & Mehr, 2013; Ostergren, 2011; Redpath et al., 2015; Townend, 2008; Weaver, 2001; Winstanley, 2003); *feedback* (Kilminster, Cottrell, Grant, & Jolly, 2007; Leggat et al., 2015; O'Connor, 2000; Ostergren, 2011; Weaver, 2001); *documentation* (Cutcliffe, 2000; Dimond, 1998; Fowler, 2013; Howatson-Jones, 2003; Hunter & Blair, 1999; Weaver, 2001); *confidentiality* (Bush, 2005; Dimond, 1998; Fowler, 2013); and *learning* (Carroll, 2007; Driscoll, 2007; Ross, 2013; Schofield & Grant, 2013).

This corroboration of clinical-supervision needs across health professions is consistent across all health professions. Whilst it is evident that there are shared principles particularly across allied health and nursing, it is not understood whether
meeting the needs of each group can be achieved collectively. Thus, the identification of allied health as an exceptional case and professional collective in this study allowed a focus on the identified needs of allied health as a single group, rather than any single profession. The choice to study allied health clinical supervision to the exclusion of other health professions enabled participants to explore their own clinical-supervision needs in a familiar collective, and further, to meet them through a policy-development process.

Allied-health clinical-supervision needs have been explored in discipline-specific studies; for example, in occupational therapy, speech pathology, physiotherapy, social work, podiatry and dietetics, identifying similar needs to those identified in this current study (Hall & Cox, 2009; Herkt & Hocking, 2010; Martin et al., 2015; O’Donoghue & Tsui, 2012; Ostergren, 2011; Paulin, 2010; Redpath et al., 2015; Weaver, 2001). Whilst this approach contributes to the collective understanding of clinical supervision, it overlooks the relevance and significance of discovering shared needs and understandings in allied-health clinical supervision. Allied health is unique as an identified collective of individual health professions. It is therefore an understandable first step to understand the clinical-supervision needs of one’s own profession before other professions.

Differences exist in allied health professionals’s clinical supervision experiences with research findings indicating that social work, psychology and occupational therapy viewed clinical supervision as more effective (Snowden, Millard & Taylor, 2016). Snowden et al., proposed that this was because psycho-social professions such as social work and psychology have a well-established history of clinical supervision within each profession and with occupational therapy, have an established set of professional guidelines for clinical-supervision expectations. Snowden et al., (2016) suggested that clinical supervision in speech pathology, physiotherapy, podiatry and dietetics was less established as part of clinical practice, reflected in the absence of specific professional guidelines for clinical supervision. These identified differences in the clinical-supervision experiences in each allied health profession highlight
individual professions at varying stages of integrating clinical supervision into regular clinical practice. It also suggests that approaching allied health clinical supervision as a collective might provide a platform for shared knowledge and experiences across allied health. Understanding the broader shared clinical-supervision needs of the wider allied-health group might, however, create opportunity to focus more easily on the remaining shared gaps or needs.

This section described the identification of the clinical-supervision needs and why identifying these needs is important to understanding the allied-health clinical-supervision experience. In this study understanding these needs was a way of using past experience to prepare for future action. In the following section I begin to describe this future action, which was facilitated through the action-research process.

7.3 Action-research-facilitated formation of a unique and relevant clinical-supervision policy

Action research facilitated the formation of a clinical-supervision policy in this study. The policy was unique in form and content and was readily accepted for implementation by the policy users. This section describes the role that action research played in the structure, content and unique qualities of the clinical-supervision policy. The outcomes of the action-research process for participants are discussed in relation to other authors’ findings and their impact on the form, content, relevance and acceptance of the policy.

Action research has been used to examine clinical supervision across a number of health professions and to develop health policy within a number of health contexts (Dold & Chapman, 2012; Elsey & Lathlean, 2006; T. Koch, Mann, Kralik, & van Loon, 2005; Matthews et al., 2008). Missing is the use of action research to develop clinical-supervision policy. My study addressed this gap by expanding on previous action-research studies, primarily through focusing on both clinical supervision and policy development. This was achieved by using action research to structure a
policy-development process that started from identification of what was needed for effective clinical supervision and transformed these needs into new practice.

A small number of authors have used action research to study clinical supervision. The justification for using action research in studies about clinical supervision are due to its compatibility with collaboration, its ability to facilitate practice change and its ability to account for the context in which the supervision occurred (Deery, 2005; Lyon, 1998; Saucier et al., 2012). Whilst there is a shared reasoning for using action research in both Lyon’s (1998) and Deery’s (2005) study in identifying the support needs of nurses, my study builds on the identification of needs to produce practical outcomes and tools for long-term implementation.

My study differs from many of the previous studies of clinical supervision, which frequently begin with an examination of an implemented program (Dawson et al., 2012; Dawson et al., 2013; Ducat et al., 2016; Kuipers et al., 2013; O’Connell et al., 2013; Taylor, 2013). My study began instead with the building of a clinical-supervision policy in a process that asked the health professionals what they needed from clinical supervision. A frequent recommendation from recent studies of clinical supervision is the presence or development of a policy to outline clinical-supervision expectations and commitment; however, none have used the policy-development process to achieve agreed understandings (Ducat et al., 2016; F. Hall & Bell, 2013; Moran et al., 2014).

Action research structures the research process through the use of repeating cycles (Creswell, 2013). Several studies have used the action-research cycle to develop policies (Fletcher et al., 2011; Israel et al., 2010). Fletcher (2011) used action research to develop a smoke-free-workplace policy with Aboriginal health workers in an Aboriginal health organisation, and used action research because of the large change in behaviour required of participants to decrease their rates of cigarette smoking. Fletcher (2011) demonstrated that action research could facilitate policy development that was relevant to both health workers and their community. This
reflects the ability of action research to transform participants and to facilitate change in the workplace (Elsey & Lathlean 2006).

My study targeted health-service employees in the development of a policy that would directly affect them; however, participants effected their own transformation throughout the process of knowledge generation and reflection. The transformation of participants as result of participating in my study is discussed in Chapter 4. In the following paragraphs I will discuss transformation, empowerment and engagement as important elements of action research that played a key role in the formation and uniqueness of the clinical-supervision policy.

7.3.1 Action research engages, empowers and transforms

Action research is used for its ability to engage, empower and transform (Deery, 2005; Hilli & Melender, 2015a, 2015b; Israel et al., 2010). These were key outcomes from the action-research policy-development process in my study (Chapter 4). These outcomes, which played an important role in policy formation, content and relevance to allied-health professionals, are discussed in detail in Chapter 4, although they will also be reviewed in this chapter.

Engagement of and with participants facilitated a collaborative and consultative policy-development process. Participants were empowered to take ownership of the information that emerged from the action-research process through their engagement in the study. Engaging with participants on issues and needs that are important to them improves participation (Israel et al., 2010). A number of authors have highlighted engagement as a facilitator of policy development and clinical supervision (Moran et al., 2014). In a study using action research in public-health policy development Israel et al. (2010) found that engagement increased participants’ capacity to be involved with policy change. The bottom-up policy development I used in my study engaged with health professionals at all levels of the health organisation, on issues and needs that participants identified were important
to them. This enabled participants to own the issues as well as the resulting solutions and changes in clinical-supervision practice.

Engagement with stakeholders at all levels of an organisation facilitates identification and management of barriers, and the acceptance and implementation of policy (Pan Canadian Joint Consortium for School Health, 2010). There are a number of challenges in developing policy, such as concerns about or resistance to the policy change, when viewed as an imposition from a top-down process. (Pan Canadian Joint Consortium for School Health, 2010). When developing the policy in my study, engagement with participants focused on issues important to them and addressed resistance to policy change by setting up shared and agreed commitment and inclusion.

Transformation of the participants, in that they generated knowledge, engaged in reflection and gained new understanding (Chapter 4), was a valuable outcome in my study that contributed to future clinical-supervision policy implementation. Several authors discuss the transformative effect of action research on participants as a result of reflection, learning and new understanding (Carr & Kemmis, 1986; Freshwater, 2005; Hilli & Melender, 2015a, 2015b).

In my study, the participants’ transformation was important because of the anticipated changes to both them and their practice. These changes in thinking and understanding prepared participants for possible future roles as advocates for extending these changes across the health organisation. This link between new understanding, transformation and empowerment is exemplified by Koch et al. (2005), who used three action-research studies to explore reflection and the value of using action research to empower participants and improve their health outcomes. They found that information within the groups was transformed into knowledge, which empowered participants to make decisions and take action. My study achieved this same transformation as health professionals were empowered to transform themselves and their own practice.
Empowerment of participants through action research has been discussed by a number of authors (Dold & Chapman, 2012; Lakeman & Glasgow, 2009). “To empower” means to “authorise” or “give power to” (Australian Concise Oxford Dictionary 5th Ed, 2009, p. 461). Participants in my study were empowered by action research through several processes: problem-solving, solution-creation and ownership (discussed in more detail in Chapter 4).

Participants were authorised in my study through ownership of the research process to solve problems and create solutions. Lakeman and Glasgow (2009) also used action research to introduce a peer clinical-supervision program to mental-health nurses, and found that action research can facilitate group ownership of the issue being studied. Increased ownership is due to the personal investment required by participating in the action-research process (Lakeman & Glasgow, 2009). In my study the ownership of the policy development required participants to invest their time; this investment enabled them to own the knowledge generated as well as the decisions made. Authorising gave participants power to suggest changes to clinical-supervision practice.

Power was given to participants through the equal involvement of all levels of allied-health seniority in the action-research process. Action research is a tool for empowerment through equal involvement of all participants (Elsey & Lathlean, 2006). Elsey and Lathlean (2006) recognised power imbalances within groups and found that using strategies to empower more-junior participants equalised group participation to share knowledge, power and decision-making. This recognition of possible power imbalances as embodied in both knowledge levels and power relationships is also addressed by Price and Chalker (2000), who reflected on the negative effect that the top-down approach used in their study may have had on implementation, due to engaging only with senior nursing staff. This is in contrast to my study, in which I used action research as a bottom-up collaborative process by including all levels of health professionals in the allied-health group. This process
authorised participants to take ownership of the information and knowledge generated and to make decisions about their own clinical-supervision practice.

This study used a bottom-up and highly collaborative policy-development process, which resulted in the policy content being specific to the allied-health groups involved. Bottom-up policy development differs from traditional policy writing in that it focuses on the issues and needs that are important to the users of the policy, rather than targeting practice standardisation and compliance (Kusserow, 2014).

My study focused on writing a policy that first and foremost reflected the experiences and needs of the participants, rather than only the needs of the organisation. This resulted in the health professionals being able to choose the content of the policy that was relevant and important to them. The issues that were identified as barriers in my study were raised and developed by the local allied-health professionals. Ensuring that the issues of importance for the action-research groups are raised is an important role of action research (Israel et al., 2010).

Missing are studies on the use of action research to develop clinical-supervision policy. Although several studies evaluate the use of action research in the development of public-health policy, few examine active participation and collaboration with staff, and none uses action research to facilitate clinical-supervision policy. The use of action research made both the approach to policy development and the outcome in this study unique.

**7.3.2 Unique form content and relevance of the clinical supervision policy**

Engagement of participants led to new knowledge and understanding of their clinical-supervision experiences, enabling identification of their clinical-supervision needs. Ownership of the policy-development process empowered the group to make decisions about the form and content of the policy. Transformation from passive to active participants in the policy-development process is essential to facilitating change (Saucier et al., 2012). The clinical-supervision policy in my study was written by and for allied-health professionals, making the content and future function of the
policy highly relevant and easily accepted amongst the groups. It is important to use locally relevant information to improve acceptance of the changes to a wider context, as highlighted by Elsey and Lathlean (2006). The participants in this current study exemplified this acceptance by welcoming new participants’ questions, in recognition of their ability to represent the questions and views of the wider allied-health group.

The structure or form of the policy varied from a traditional policy structure, as it incorporated both policy principles and guidelines into one document. Although local procedures were in place within the health organisation to structure the policy, deviation from this structure occurred to improve the policy’s functionality. The health organisation’s approach to policy development is consistent with a top-down traditional approach, through an adherence to conventional policy writing (Collins & Patel, 2009). Collins and Patel (2009) describe separating the policy and procedure as an expected approach to policy formatting. Participants in this current study created a policy structure that met their needs by encompassing the policy principles and procedural guidelines in one document. This suggests that a worthwhile policy structure might be one with the flexibility to meet both the needs of the organisation and the needs of the policy users. The use of a bottom-up action-research process is important to ensure the identification of important issues across all staff levels (Hilli & Melender, 2015b).

The results of the study suggest that a health organisation’s flexibility in potential health-system policy development could be advantageous, particularly where health professionals are at the forefront of implementation. This anticipation of barriers and issues prior to policy implementation reduces the need to raise them upon implementation. Allowing health professionals the freedom to explore their own needs and understand and incorporate these into a significant policy may also promote consideration of and action on the known and unknown barriers to future implementation.

A number of authors support the engagement of health professionals in the development of clinical-supervision programs, which suggests that this is not a
common occurrence (Driscoll, 2007; Moran et al., 2014; Price & Chalker, 2000; Ross, 2013). Likewise, the presence of ongoing requests for structure in clinical supervision reveals an opportunity in the field of clinical supervision. This study afforded the opportunity for action research to provide both health professional engagement and a supporting structure to achieve adequate clinical supervision in allied health. The findings support action research as a method of identifying allied-health clinical-supervision needs and supporting a policy-development process to address them.

The time allocated to the policy development process is discussed in Chapter 6 and might be regarded in the everyday clinical setting as unrealistic. The costs of policy development processes are commensurate regardless of the technique used (Kusserow, 2014). The outcomes from the allocated time and action-research process, were more than the policy as a product. Empowerment of, and engagement with health professionals built a sense of trust between the organisation and the health professionals, through the agreement of policy. Building trust is consistent with trust theories presented in Chapter 1 and the effect this trust can have on policy implementation (Jenkins-Smith & Sabatier, 1994; Levi, 2000). The process and the policy are thus equal and realistic partners in the implementation and as proposed by Levi (2000), require less resources allocated to implementation and monitoring as a result of the investment in building mutual trust between the health professionals and the health organisation.

In this study, the action-research process engaged with, empowered and transformed participants, which led to the development of a unique and tailored clinical-supervision policy. The policy was thus highly relevant and acceptable to the allied-health professionals, and was a practical realisation of their needs and requirements.
7.4 An Integrated Model of Supervisee Needs In Clinical Supervision

The Allied Health Key Dimensions Model of clinical supervision (Figure 6) emerged from my study as a result of a hermeneutic meta-interpretation. This was the first meta-interpretation of the whole text set, and occurred following the action-research groups. The development of the model and its purpose are discussed in detail in Chapter 6 within the context of the published paper. The following paragraphs extend the discussion of past clinical-supervision models to include a contextualisation of the Allied Health Key Dimensions Model within current practice. I compare the model (Figure 6) to existing allied-health clinical supervision models that had not been available to me prior to undertaking the meta-interpretation, and had not been included in the peer reviewed paper in Chapter 6, as I had submitted the manuscript prior to the publication of these papers.

The model is a visual representation of the needs of allied health in this study. A key feature of the model is that it places the needs of the supervisee at the centre of the model. This conveys both the significance of the supervisee to the clinical supervision process and the movement through time using the centre of the model as a starting point for the user.

The needs of the supervisee are the central starting point for the Allied Health Key Dimensions Model, as is the case in the Connecting Practice model by Nancarrow et al. (2014). The Connecting Practice model overtly places the clients around the supervisee. The Allied Health Key Dimensions Model encouraged a clarification of the centrality of the supervisee to the allied-health clinical-supervision process, which occurred within the participant conversations about the function and purpose of the clinical supervision. In this way the Allied Health Key Dimensions Model facilitates communication about the four domains and ensures that it applies to each individual context.

In my study the participants made client work a priority by defining clinical supervision as “clinically focused”, which was elaborated as “Clinical supervision is
not a counselling session; it has a focus on clinical work” (5.4). In this way the participants were engaged in the formation of the underlying principles of their own clinical supervision. This engagement generated an understanding through discussion and decisions across the action-research cycles about why a focus on clients was important. The policy-development process used in my study helped the health professionals trust that their needs would align with client and organisational needs; making it an unnecessary domain in the model.

The use of hermeneutics in combination with action research created a space for the policy-development process to be based in conversation (Smits, 1997). This was an important part of the method used to create a common language and understanding, from which the experiential text was generated (Chapter 2). The Allied Health Key Dimensions Model that emerged from this shared language and understanding was thus based on the allied health professional’s clinical-supervision experiences.

This text source within my study was the allied-health experience of clinical supervision. Nancarrow et al. (2014) predominantly used grey literature (government policies, documents and clinical guidelines) in their thematic analysis of clinical-supervision frameworks in rural and remote allied health. The difference in the source of texts that informed the Allied Health Key Dimensions Model from those that informed the Connecting Practice model results in different functions for each model. The Connecting Practice model presents an overall schema of health-professional support, including supervision as one element in the broader context of available support. The Allied Health Key Dimensions Model, in contrast, functions as a specific tool to address clinical supervision. This function fills a gap in the available knowledge and understanding about what is needed in clinical supervision, whether this is in the context of introducing clinical supervision, or reviewing already established practice.

Nancarrow et al. (2014) highlighted that the available supervision frameworks frequently reflect the needs of those writing the documents. This may leave gaps in the clinical supervision-requirements for allied health. The Allied Health Key
Dimensions Model was conversely based on the experiences of allied-health professionals, and is thus a reflection of those experiences and needs. When placed in combination with action research, the policy-development process can create tailored clinical-supervision outcomes.

A recent model of clinical supervision that shares some elements of the Allied Health Key Dimensions Model is the Y Model by Ducat (2016). Ducat’s model describes facilitators to effective allied-health clinical supervision in rural and remote locations, the supervisor-supervisee fit, and a positive organisational culture for clinical supervision. The Allied Health Key Dimensions Model encompasses both elements: overtly in the relationship domain, and less obviously in its assumption that clearly defined and available clinical supervision would ensure a positive supervision culture. This demonstrates the importance of the Allied Health Key Dimensions Model in having clinical-supervision domains that account for the range of issues presented in the allied-health clinical-supervision experiences.

In a clinical context the Allied Health Key Dimensions Model is a practical tool to help health professionals develop or evaluate their own approach to clinical supervision and policy development, using the model as a guiding structure. The model builds on studies examining allied-health-specific clinical-supervision needs, such as Sweeney et al., (2001) in occupational therapy, Redpath (2015) in physiotherapy and Strong (2004) examining allied health in mental health. The Allied Health Key Dimensions Model also serves as a point of comparison for those looking at clinical-supervision implementation and contemplating a starting point tailored for allied health (described in detail in Chapter 6).

In a comprehensive literature review of support interventions, including clinical supervision, Moran (2014) found that when stakeholders are actively involved in the design, implementation and evaluation of support programs, the programs’ culture, understanding, participation and sustainability improve. My study provided extensive opportunity for engagement with the allied-health professionals through the use of action research (Chapter 4). I was able to understand the importance of engaging
with stakeholders in the design of clinical supervision through the process of developing the Allied Health Key Dimensions model.

In this section I compared the Allied Health Key Dimensions Model to recent clinical supervision models for allied health (Ducat et al., 2016; Nancarrow et al., 2014). These models add to a focus on clinical-supervision needs based in past experience and literature. My study enables a future clinical-supervision experience by building knowledge and capacity within the health professionals. The Allied Health Key Dimensions Model is a tool for discussions about content and purpose to develop in mutuality with the supervisee within the health workplace. The model emerged from a meta-interpretation of allied-health experiential texts. When this model is combined with the action-research process, a set of tools to examine and implement clinical supervision emerge. The model supports both health professionals and organisations in a shared understanding of and approach to the implementation of clinical supervision by highlighting key aspects of effective clinical supervision.

7.5 The Clinical Supervision Toolkit

The action-research clinical-supervision policy development process and the Allied Health Key Dimensions Model were outcomes of my study with practical application in the workplace (Chapters 4 and 6). The model encapsulates allied-health clinical-supervision needs. The action-research approach to policy creation provided a structured approach to collaborating with health professionals about clinical supervision and their specific needs. I recognised a need to integrate these findings into an accessible resource that could reflect the practical and theoretical outcomes of my study. The development of a conceptual framework, the Clinical Supervision Toolkit (Figure 7, Chapter 6), fulfilled this need for a transferable and self-explanatory resource that allied health professionals and health organisations could use to understand and approach clinical supervision.
In the process of this study I discovered a gap in allied-health clinical-supervision conceptual frameworks. A conceptual framework is one in which concepts play a key role and which provide an understanding of complex phenomena (Jabareen, 2009; D. Smith, 2015). I applied this definition in my search for allied-health clinical-supervision conceptual frameworks and located only one, in the work of Nancarrow et al. (2014). I discussed Nancarrow et al. in Section 7.4 in the context of being a model because the title of the paper is “Connecting practice: a practitioner centred model of supervision” (p.235). However, they refer to the model as a “support framework” (p.236). For this reason I have included it as an example of a conceptual framework, as it is also consistent with my definition of such frameworks.

Due to the small number of conceptual frameworks available, I also included those targeting issues relating to health professionals’ wellbeing, retention and governance; qualities shared with clinical supervision (Hall & Bell, 2013; Schoo, Stagnitti, Mercer, & Dunbar, 2005). Two of these chosen studies target the rural and remote health context with a specific focus on allied health (Nancarrow et al., 2014; Schoo et al., 2005).

The frameworks by Hall and Bell, Schoo and Nancarrow et al. explore health-professional support that includes clinical supervision as one element among many, such as professional development, support, mentoring, in-servicing, journal clubs or peer review; domains that are also explainable within the Clinical Supervision Toolkit Schoo et al. (2005) proposed a conceptual model to encapsulate the difficulties encountered in allied-health recruitment and retention in rural and remote settings. They highlighted factors that cannot be changed in a health professional’s working life, such as personal factors, and suggested other factors that can be influenced, such as education, support and management systems. They described clinical supervision as only one of those factors. Likewise, Hall and Bell targeted health-professional support, of which one component was clinical supervision. The gaps identified in allied-health clinical supervision described in Chapter 1 suggest that allied-health clinical supervision practice is in the process of development. In
conceptual frameworks where clinical supervision is only one component, the ability to target clinical-supervision practice may be reduced.

Nancarrow et al. propose a conceptual framework that gives equal weight to professional development, support and clinical supervision. They propose both a model and framework that can be used in a rural and remote allied-health context. A model is a method of delivery and serves a different purpose to conceptual frameworks (Kennedy, Hill, Adams, & Jennings, 1996). It is difficult to require a structure to function as both model and conceptual framework. Nancarrow et al. propose a model that functions as a conceptual framework, however includes clinical supervision as one of three concepts in a broad model addressing professional support, which makes it difficult to identify targets for improving allied-health clinical-supervision practice.

My study focused only on clinical supervision, as the motivation for the study was to develop a clinical-supervision policy. This specific focus on clinical supervision enabled a refinement of the Clinical Supervision Toolkit and the tools that emerged from this study. Conceptual frameworks that focus on the granular elements and concepts of supervision may be more useful to both health organisations, and allied-health professionals. The Clinical Supervision Toolkit differs as a conceptual framework by specifically addressing allied health clinical supervision needs as a collective group and proposing a practical method of for their realisation.

The Clinical Supervision Toolkit addressed the gaps and problems in allied-health clinical supervision identified in Chapter 1: a paucity of studies specific to allied-health clinical supervision, a lack of a shared understanding of allied-health clinical supervision and what is needed, the need to involve allied-health professionals in the design and development of clinical supervision and a need for structure. In the following paragraphs I will describe how the Clinical Supervision Toolkit addresses each of these needs.
7.5.1 **Paucity of allied-health-specific studies**

As discussed throughout this exegesis, while studies examining allied-health clinical supervision are increasing, there are still fewer compared to other professions (Pearce et al., 2013). Moreover, a clear paucity of conceptual frameworks in allied-health clinical supervision was apparent, as well as a complete absence of those with a specific focus on the elements needed to improve clinical-supervision practice in allied health.

The Clinical Supervision Toolkit contributes in two ways to the allied-health clinical-supervision literature. First, it provides a conceptual framework, targeting the theoretical concepts and elements important to allied health through the integration of practical tools with the conceptual findings of the meta-synthesis. “Theoretical” is defined as “concerned with knowledge but not with its practical application” (Australian Concise Oxford Dictionary 5th Ed., 2009, p. 1496), and “practical” is defined as “feasible, concerned with what is actually possible” (Australian Concise Oxford Dictionary 5th Ed., 2009, p. 1116). The Clinical Supervision Toolkit is a receptacle for both theoretical and practical aspects of approaching the development and thinking about clinical supervision. It brings together the theory and deep thinking from empirical texts constructed during this study and developed through a deep meta-interpretation and the practical aspects of the policy-development process. Thus it balances Gadamer and Risser’s (1979) concern of interpreting either too narrowly in the practical space, or too broadly in the theoretical space. “The connection between the universal desire to know and concrete practical discernment is a reciprocal one” (Gadamer & Lawrence, 1982, p. 112). Gadamer conveys a necessity to think philosophically about practice so as to remain open to new ideas, and to question accepted ways of working (Gadamer & Lawrence, 1982). The Clinical Supervision Toolkit incorporates the theoretical knowledge and practical possibilities of my study into a resource that encourages allied-health professionals to approach clinical supervision in a new way. The focus on clinical supervision in both a practical and theoretical sense in Clinical Supervision Toolkit differs from
other frameworks, which focus on either practical tasks or broad theoretical constructs (Hall & Bell, 2013; Nancarrow et al., 2014).

Second is the contribution made by the individual elements within the Clinical Supervision Toolkit, The Allied Health Key Dimensions Model and the action-research process used to develop the clinical supervision policy were key findings from my study, and were submitted as publications within the field of allied-health clinical supervision. These new ways of understanding and approaching clinical supervision have contributed new knowledge and increased the number of studies specifically targeting allied-health clinical supervision.

7.5.2 A shared understanding of clinical supervision and what is needed in allied health

As identified in Chapter 1 and discussed throughout this exegesis, a lack of shared understanding exists in allied health about what is meant by the term “clinical supervision” (Kuipers et al., 2013; Pearce et al., 2013). In my study I demonstrated the ability to achieve a shared meaning and understanding across allied-health professionals and the health organisation, through collaboration, engagement and discussion. The Clinical Supervision Toolkit does not present a definition of allied-health clinical supervision; instead, it is a resource to find agreement between the users of the Clinical Supervision Toolkit, which may include allied-health professionals, the health organisation leaders and other health professionals, through structured discussion and consideration of the key concepts, components and tools within the toolkit structure. For example, discussions about the three key components could promote recognition about the role that Reflection, People and Practice play in allied-health clinical supervision. Further discussion is prompted through the intersection of these three factors with the Allied Health Key Dimensions Model and the action-research process used to develop clinical-supervision policy about how to achieve shared aims and goals for clinical supervision.
7.5.3 Involvement of allied-health professionals in the design and development of clinical supervision

The purpose of the Clinical Supervision Toolkit is to facilitate conversation between participants in allied-health clinical supervision, such as allied-health professionals, the health organisation leaders and other health professionals, to create an understanding about clinical supervision in allied health. This is the beginning of engagement with and participation in the clinical-supervision development process. Participants in the Clinical Supervision Toolkit include the clients who are the recipients of improved clinical care, the allied-health professionals providing the care and receiving the clinical supervision and the supporting health organisation. Through a conversation structured by the Clinical Supervision Toolkit, agreement about allied-health clinical supervision can be established through negotiation and exploration with participants.

In clinical-supervision studies, action research provides an enactment of collaboration and engagement (Hilli & Melender, 2015a; Israel et al., 2010; L. Koch, Arhar, & Rumrill, 2004; Lyon, 1998). The action-research process of developing clinical supervision policy applied in my study used collaboration and engagement to actively engage with participants regarding changes to clinical-supervision practice (Chapter 4). The use of the arrow in the Clinical Supervision Toolkit defines action research as a process of engagement and as a continual process; it informs the user that the approach to clinical supervision is not a singular set of actions or approaches, but a constant and evolving one involving all those participating in clinical supervision. The inclusion of People as a key concept highlights the importance of discussing the role participants take in designing and agreeing upon an approach to clinical supervision.

The Clinical Supervision Toolkit translates the new tools and knowledge from my study into an accessible framework with which to approach and understand clinical supervision. It can be accessed and understood regardless of the user's place on the clinical-supervision continuum or within a health organisation.
7.5.4 A need for structure

“Structure”, as defined in Chapter 6, means to “give structure to; organise; frame” (Australian Concise Oxford Dictionary 5th Ed., 2009, p. 1431). It is an essential requirement when approaching clinical supervision in allied health, as shown in the literature text and presented in Chapter 1. The Clinical Supervision Toolkit provides structure in three ways.

First, it is, itself, a structure, with the tools and concepts of allied-health clinical supervision contained within the outer border. I presented clinical supervision in the Clinical Supervision Toolkit as a set of concepts and structures that can be used to create an understanding of clinical supervision and what might be required.

Second, the interaction of the parts of the toolkit adds structure. The model demonstrates that a structured approach to evaluating clinical-supervision needs is central to approaching clinical supervision. The interaction between the three key components of Reflection, People and Practice, the Allied Health Key Dimensions Model and the action-research process of developing clinical supervision policy, provides structure to discussions about how they actually interact, and what this means for understanding and enacting clinical supervision.

Third, the individual parts of the Clinical Supervision Toolkit can act as independent structures. For example, the Allied Health Key Dimensions Model can be used to evaluate and review current clinical-supervision practice within the four domains of needs, clarity, relationships and accessibility to guide the approach. Likewise, the action-research process structures an approach to policy development where both the approach and the policy itself add structure.

As a whole, the Clinical Supervision Toolkit enables a structured approach to understanding and planning clinical supervision, and presents the issues of importance to begin the conversation. The Clinical Supervision Toolkit could be ideally used to create in-depth discussion about what clinical supervision means to a group of allied-health professionals or a health organisation seeking to create shared
meaning or agreement on a way forward for allied-health clinical supervision. For example, a health organisation may have already made several unsuccessful attempts to introduce clinical supervision across all allied health. Compliance may have been poor despite a policy being in place for some time. The Clinical Supervision Toolkit could be used to commence an allied-health-wide conversation. The aim could be to move the allied-health professionals away from only thinking about the practical aspects of why clinical supervision is or is not occurring. The Clinical Supervision Toolkit could provide an opportunity for allied-health professionals to reflect conceptually on a shared understanding of clinical supervision by moving through each toolkit component. Discerning the needs of the groups would begin with a review of current beliefs and practice, and questioning of these would be facilitated through discussing the key concepts of Reflection, People and Practice. Enacting this new and agreed position on allied-health clinical supervision would occur through an action-research process, which would also ensure that the process initiated by the Clinical Supervision Toolkit was one of continual review. For example, once an allied-health clinical-supervision policy had been developed, the policy would undergo regular review through the action-research process. This would ensure that the views and understanding about allied-health clinical supervision continued to be discussed and to progress. This process would also account for and include allied-health professionals entering the health organisation who had not been involved in the development process.

Including health professionals in the design and development of their own clinical supervision is an important step towards successful implementation, although it is not yet regularly practiced (Cottrell, 2002; Ross, 2013). The Clinical Supervision Toolkit is a foundation for a new understanding of and approach to allied-health clinical supervision, which can instigate a significant change in how health organisations approach clinical-supervision implementation through engagement and discussion.
7.6 Chapter Summary

In this chapter I discussed the four important findings from this study:

1. The importance of identifying the clinical-supervision needs of allied-health professionals and the methods used to achieve this. The needs were identified by the participants in the study, and were relevant to their clinical-supervision experiences and their context.

2. The use of action research to facilitate policy development and to engage, transform and empower participants. Action research was found to be a successful process to develop clinical-supervision policy. Action research structured the policy-development process in a predictable and time-limited way. The policy provided a place to record and structure the identified needs of the participants. The guidelines that were developed served to instruct the user on how best to meet the needs, which were documented as 12 key principles of clinical supervision.

3. The development of a clinical supervision model. A hermeneutic process enabled a meta-interpretation of the whole texts. The Allied Health Key Dimensions Model of clinical supervision emerged from this new horizon. This model provides a visual guide to understanding the core principles to consider when approaching clinical supervision as an individual, group or health organisation. One key feature is the placement of supervisee needs at the centre of the model, and therefore of the whole approach to clinical supervision.

4. The development of a conceptual framework using a toolkit metaphor, to translate the new knowledge from the study into a practical set of tools with which to establish clinical supervision in a health context. The Clinical Supervision Toolkit is a conceptual and practical expression of the outcomes from this study; used together, they can lead to the development of a collaborative clinical-supervision policy that addresses the needs of both the health profession and the health organisation.
This study demonstrated a new understanding of clinical supervision in allied health and the importance of true collaboration with allied-health professionals in the design and implementation of allied-health clinical supervision. The tools developed make it possible to achieve this in range of health contexts, whilst acknowledging and allowing for consideration of individual and organisational requirements.
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CHAPTER 8: CONCLUSION

8.1 Introduction

Throughout my study, I aimed to explore the experience of clinical supervision in allied health, to investigate action research as a possible policy-development tool and to use this understanding to provide a foundation on which to base clinical-supervision implementation and policy development. I focused on these issues because I had initially found gaps in understanding allied-health clinical supervision, what was needed and how it could best be implemented.

As discussed in Chapter 1, the gaps in clinical governance within the New South Wales health system identified by the Garling Inquiry (2008) included a lack of shared understanding about clinical supervision; the Inquiry resulted in recommendations for clinical supervision policy and implementation. The participating health organisation in which I work was also keen for me to assist them in developing a clinical-supervision policy. I was also motivated to help because I knew that there are several benefits for allied-health staff when they receive high-quality supervision, such as staff well-being and clinical safety and governance (Bishop, 2008; Ducat et al., 2016; Hall & Bell, 2013; Saxby et al., 2015). Further benefits also include a possible approach to allied-health clinical supervision that supports a more sustained approach to its implementation.

The hermeneutic method used in my study facilitated a deep understanding of the clinical-supervision experience, structured a unique approach to identifying clinical supervision needs and guided the transformation of these needs into tangible tools for approaches to clinical supervision. The interpretive theoretical paradigm framed the understanding of each participant’s experience in the context of my own interpretation, the health organisation and allied health in general.

This study had several outcomes. Allied-health clinical-supervision needs were identified, first within the context of the policy-development process and second as a
result of a meta-synthesis. These needs were responded to through the policy, the Allied Health Key Dimensions Model and the Clinical Supervision Toolkit. As a result of these outcomes and products, a new understanding and approach to clinical supervision was established.

In this final chapter I outline recommendations for approaching allied-health clinical supervision and future research and development. The recommendations given in this concluding chapter integrate the findings with a vision for future policy, practice and research. The unique contributions and implications of the findings are described in the context of the broader allied-health clinical-supervision landscape as initiating new thinking and new practice. Limitations of my study are examined to show the credibility and transferability of the outcomes. I conclude the exegesis with a reflection on the findings and their place in future allied-health research and practice.

### 8.2 Recommendations

*Recommendation 1: There is value in each organisation recognising the specific needs of its allied-health professionals*

I found that identifying allied-health clinical-supervision needs clarified expectations and created shared understanding about clinical supervision within the health organisation. I also found that the process of identifying the needs of the individual, professional group and organisation provided a forum for agreed ways of meeting these needs. A commitment to recognising clinical-supervision needs is an important step in including current barriers and facilitators within each health organisation’s approach to allied-health clinical supervision. The tools generated by this study facilitate this task by providing a scaffold for such discussions.

*Recommendation 2: The use of action research may be useful for facilitating the implementation and sustainability of clinical supervision in allied health.*
I found action research a valuable tool to evaluate current practice and build a collaborative clinical-supervision policy. In this study, action research encouraged ownership of the process, enabled new learning and knowledge and created change in participants and their approach to clinical supervision. I found that participating in action research resulted in transformation of participants. These transformative capabilities of action research can be harnessed as an instrument for implementing clinical supervision. This has led me to recommend that organisations should harness this transformation in the development of implementation champions from the action research process. These supervision champions could herald the message of change in practice through the action-research process, to facilitate an understanding of new approaches or practice.

The focus on participants meant that their needs were paramount in the policy-development process; this was essential in the establishment of an agreed approach between policy users and the health organisation. I recommend the use of action research as a policy-development process especially when allied-health professionals are working towards a mutually agreed goal.

Action research could provide ongoing support to protect the implementation of clinical supervision from an erosion of compliance or potential benefits through investment in health professional and established trust between the health professionals and health organisation. Thus I recommend regular participation in action research to review clinical supervision and sustain its ability to meet the needs of both the organisation and the supervisees.

Recommendation 3: Policy can be used to structure clinical-supervision implementation.

A health policy is one way to clarify expected behaviours and accountabilities within a health organisation. In this study, I found that a detailed and tailored clinical-supervision policy can serve as a guiding structure to achieve a shared understanding of clinical supervision and its implementation. Policy can be seen as a
structure to support a clinical-supervision agreement for allied health. The agreement moves two ways, because both the health professionals and the organisation have the opportunity to voice their needs and have them met through the policy itself. I thus recommend that clinical-supervision policy could be used to structure an understanding between a health organisation and health professionals, to establish or improve current clinical-supervision practice. Policy can commit the health professional’s time, attention and adherence and the health organisation’s resources and support.

I also found that a flexible approach to policy form and content met the needs of the participants, which can improve the relevance and readability of, and compliance with, the policy in the clinical setting. A policy that is written with the user central to its structure and content is more likely to be relevant to their needs (Ross, 2013). I recommend that a similar approach could also be considered for clinical-supervision policies in which change plays a significant and anticipated part of implementation.

*Recommendation 4: The Allied Health Key Dimensions Model for clinical supervision may be useful for evaluating and implementing clinical supervision in local settings.*

The four dimensions in the model created opportunities for discussion about a common vision for clinical supervision. This could be the beginning of a shared understanding about what clinical supervision means in the specific allied-health context. The four dimensions provide a structure for both broad and very specific evaluation, planning and implementation.

Thus I recommend that the Allied Health Key Dimensions Model be used in an organisational capacity to evaluate clinical-supervision practice on a broad level, and to inform a plan of action to improve that practice. Applying the four dimensions to an individual’s clinical-supervision practice is one possible approach to individual ownership of the process for identifying and meeting individual needs.
Recommendation 5: Share the Clinical Supervision Toolkit across allied health to engender ownership and create knowledge about allied-health clinical supervision.

The Clinical Supervision Toolkit closes the circle on the recommendations from this study because, while it is the last finding from the study, it is the first recommended action to take when approaching clinical supervision in allied health. It is recommended that health professionals become familiar with the Clinical Supervision Toolkit and engage with it as a springboard for group discussion about the interaction of the concepts and tools, and what this means for their own understanding and approach to clinical supervision. This shared discussion lets them create knowledge and ownership about their own clinical supervision needs, situation and context.

The Clinical Supervision Toolkit is a nexus between the explorations of an allied-health professional’s clinical-supervision needs and the implementation of those needs into their own specific context. A commitment to structure in the form of policy, people and improved clinical supervision practice is easy to understand and put into action in this conceptual framework. The Clinical Supervision Toolkit is a ready-to-access resource that supports a bottom-up approach to establishing and sustaining clinical supervision.

8.3 Future research

Recommendation 1: Evaluate the ability of the Clinical Supervision Toolkit to facilitate clinical supervision across broader health settings, contexts and professions.

An evaluation of the use of this conceptual framework and the impact it has on the implementation of clinical supervision is a necessary next step, as the scope of this study did not extend to evaluating the tools developed. An evaluation of the applicability of the Clinical Supervision Toolkit to other health environs and its usefulness as a facilitative tool in establishing clinical supervision would strengthen
its use as an implementation tool. This research would begin a wider dialogue about whether the key inclusions for allied health are applicable to other health professions, and thus whether a shared clinical-supervision structure might be beneficial to implementation and sustainability. An evaluation of the applicability of this study’s results within other health professions would contribute more broadly to the supervision literature, and begin a discussion examining the broader clinical-supervision commonalities across health professions.

*Recommendation 2: Evaluate action research as a tool for policy development and implementation.*

Evaluating the effect that action research has on facilitating allied-health clinical-supervision policy development and implementation is a useful next step for future research in clinical supervision. Challenges to implementation within allied health could be addressed through the use of a bottom-up policy-development process. I found that action research can develop an effective clinical-supervision policy. Future research could examine these policies after implementation from the perspectives of compliance, participant satisfaction and long-term sustainability.

The outcomes of this study suggest that formal evaluation of policy implementation would be a future step in providing evidence for the success of the action-research policy-development process in overcoming some of the implementation problems occurring in nursing, such as individual and organisational clinical-supervision culture and support (Cottrell, 2002; Driscoll, 2007). Further study on the action-research process could evaluate its effect on the long-term sustainability of clinical supervision. This could deepen understanding about the importance of using a collaborative and participative process to guide action in clinical supervision.

*Recommendation 3: Research the effectiveness of the Allied Health Key Dimensions Model of clinical supervision as a tool to evaluate and implement clinical-supervision policy and practice.*
This research could focus separately on the health organisation’s and individual allied-health professional’s use of the Allied Health Key Dimensions Model. This research could be established within allied-health sectors that currently do not practise clinical supervision, or where an evaluation of current practice is required. Following an understanding about the model’s effectiveness in allied-health clinical supervision, consideration could be given to applying its principles within other health professions. Parameters of this study did not allow for the evaluation of the model in the implementation or evaluation of clinical supervision. Its effectiveness and applicability to other health environs would strengthen its usefulness as a clinical-supervision tool.

8.4 Limitations

As a qualitative body of research, my study approached clinical supervision within one health organisation in New South Wales, Australia. Using a hermeneutics-inspired action-research method, fulfilled the needs of the participating health organisation for an allied-health clinical supervision policy, and more generally, for an organisational approach to allied-health clinical supervision. The research outcomes from my study developed an understanding of ways to approach allied-health clinical supervision in the health workplace. These outcomes may be transferable to other health organisations, which may have similar goals for and requirements of allied-health clinical supervision. A focus on similarities in geographical distribution and allied-health demographics as a contextual comparison may not determine transferability. Rather, an openness to collaboration, which played a key role in my study, may be a requirement for this approach to be used in other contexts.

A focus on allied health as a group gave voice to the collective needs across allied health. Whilst it is hoped that this collective approach focused on shared needs, it did not explore or compare differing needs across allied health professions.
One limitation associated with my being both a researcher and a manager in the health organisation was the possibility of my having a specific investment in the policy direction and content. It is also feasible to expect that as a senior manager within the health organisation, my actions as a researcher might be influenced by the expectations of the organisation. I responded to this limitation in myself through reflexivity. This required me to examine and acknowledge my role as interpreter and the effect this might have on participants or interpretation. It was essential that, as a co-researcher within the action research groups, I attempted to relinquish authority and expertise and reflect upon any particular investment in a specific research outcome (Finlay, 2003). Whilst this was a limitation on methodology, the involvement of a senior manager in a collaborative approach to allied-health clinical supervision in the health workplace could facilitate a normalisation of an alternative approach to changing allied-health clinical-supervision practice.

The development of the clinical-supervision policy using action research is strongly supported by the findings in study; however, it is important to consider the ease with which the policy was developed. Not usually considered a limitation, the context in which the clinical supervision policy was developed should be considered. The policy was developed within the context of the Garling Inquiry (2008), which required each health organisation to report on its progress in addressing the improvement recommendations. This reporting and attendance to the recommendations provided motivation within the health organisation to provide the resources required to develop the policy.

The success of the policy-development process and high level of support within the organisation can be explained by applying Kingdon’s framework for analysing policy and processes (Kingdon, 1984). This framework explains why the best ideas are acted upon at some times and not others. Applying Kingdon’s (1984) framework in my study suggests the need to have an alignment of clinical supervision as an important agenda, a person ready to facilitate the policy-development process and the political patronage to support it. The existence of these three elements may have
affected the process of policy development and implementation, and contributed to the high level of support for the policy-development process, and ease with which it was achieved. The possibility that this may not be present in all health organisations should be considered to understand and anticipate possible challenges not encountered within this study.

The outcomes from my study suggest that approaching allied-health clinical supervision requires a sustained commitment to developing and reviewing an allied-health clinical-supervision policy, and revisiting a shared understanding of its meaning and relevance to the health organisation and allied-health professionals. Limitations to this approach include a significant time commitment from the health organisation and health professionals. The outcomes of this study, however, showed that this investment in time at the beginning of developing an allied health clinical supervision policy has long-term advantages for implementation success. A further limitation to using this approach to allied-health clinical supervision may be the eventual arrival of allied-health professionals within the health organisation who have not participated in the shared understanding of clinical supervision or the shared policy-development process. The approach proposed in the Allied Health Clinical Supervision Toolkit would ensure that establishing and maintaining a shared understanding and policy would be a continual process of regular revisiting both the document and the beliefs and values behind it. The professionals new to the health organisation and its approach to clinical supervision could then become active participants in the ongoing process, helping them make a commitment to the relevance and meaning of allied health clinical supervision. The clinical-supervision policy document thus becomes a living document, rather than one that is developed and left for users to understand and implement themselves. The approach, policy and implementation become one process.

### 8.5 Unique Contributions and Implications of This Research

My findings expand on profession-specific research into allied health as a group, and examines shared principles that might be applied in clinical supervision. The study
has implication for new ways of thinking about allied-health clinical supervision, developing allied-health clinical supervision policy and changing allied-health clinical-supervision practice. This has implications for understanding that policy development can be more than words and directives, and that real practice change can emerge from collaborative and transparent processes. I found action research to be an effective way of approaching policy development. This approach had implications for practice change and clinical-supervision implementation, through empowering health professionals as co-researchers and owners of the process.

It is anticipated that the Clinical Supervision Toolkit, which features the Allied Health Key Dimensions Model of clinical supervision and action-research policy development, could be used by health professionals and health-organisation leaders to engage with each other in establishing successful clinical supervision in allied health. It could then follow that health professionals outside allied health would use the tools as a support for establishing clinical supervision in their own specialisations.

8.5.1 New thinking

I propose that my study provides a new way of thinking about policy and policy development for clinical supervision. The identification and significance of clinical-supervision needs, though well described in several studies, is not generally suitable for a traditional top-down policy development process. My study highlights the benefits of building the needs of the supervisees into the clinical-supervision policy as a way of planning for effective implementation, and demonstrates the necessity and possibility of using policy to meet those needs.

The bottom-up policy-development process introduced a new way of thinking about policy as a change-management tool, not just a series of aspirational or directional statements. This shift away from the top-down policy-development approach presents the barriers to implementation raised by participants as a welcome addition to the policy-development process. One significant change in thinking that I
anticipate is health organisations’ acceptance of action research as a collaborative way to develop clinical-supervision policy and to facilitate effective implementation. I have argued that this concept of engagement is a new way of approaching policy development and an acknowledgement of the value of policy users as important sources of knowledge.

Deep thinking and reflection about allied-health clinical-supervision practice also constituted a new way of thinking about practice. The practical aspects of clinical supervision were viewed and acted on through a reflective lens. Thinking about practice and its meaning before acting integrated the theoretical with the practical as a new way of approaching allied-health clinical supervision.

8.5.2 New practice

My findings in this study that contribute to new practice are a result of new thinking, processes and tools. No other studies using action research to develop clinical-supervision policy could be located.

This study responded to gaps in structure and agreement in clinical-supervision practice by providing a structured approach to closing them. First, the action-research process provided a practical structure for achieving a shared understanding of clinical-supervision needs in allied health. These needs were then responded to through the action-research process in the development of a clinical-supervision policy. This is new practice in both clinical supervision and policy development. This process is a practical demonstration of an underlying belief that the users of the policy knew what they needed and how to achieve it.

I proposed a set of resources for use in approaching clinical supervision in allied health that filled a current gap in available tools for this purpose. The development of the Allied Health Key Dimensions Model provided a platform for evaluating and implementing clinical supervision. This model is unique in that it represents a broad range of allied-health experiences, can be used at an individual or organisational
level, and can be used to initiate and evaluate clinical supervision at any point along the development continuum.

Finally, I suggest that the Clinical Supervision Toolkit translates the new knowledge and tools from this study into an easily understandable and applicable framework. The toolkit is a conceptual application of the findings from my study, giving health leaders and professionals a starting point for approaching clinical supervision. It acts as a conceptual framework for the implementation of allied-health clinical supervision at all organisational levels and settings. It presents a useful addition to attempts to fill the gap in approaches to clinical-supervision implementation in allied health.

The unique contributions to changing thinking, policy and practice included: a deeper understanding of the clinical-supervision needs of allied health, an action-research policy-development process and a set of resources to influence the implementation of clinical supervision. More broadly, my study contributes to the discussion about the difficulties of implementing and sustaining clinical supervision, and I offer a framework to explain this.

8.6 Concluding Remarks

The overall aim of this exegesis was to explore the experience of clinical supervision in allied health, to investigate action research as a possible policy-development tool and to provide a foundation on which to base the implementation of clinical-supervision policy development.

An interpretive philosophical framework and hermeneutic methodology facilitated a unique understanding of the allied-health professionals in this study. The clinical-supervision needs were identified with participants using a survey and action-research approach. Asking health professionals what they need and then acting on these needs is a new way of thinking about policy development, and about the positive role participants can play as policy users.
Action research was used as a clinical-supervision policy-development tool to create changes in participants and establish new ways of thinking about clinical supervision and its implementation. Policy is used as a tool of compliance; however, the use of action research and engagement with participants in the development of their own policy created a new way of approaching policy-development as a practice.

Structure was provided throughout the study by the use of action research as a process and by the Allied Health Key Dimensions Model and Clinical Supervision Toolkit. These structures address gaps in current practice and provide new tools to approach clinical supervision from initiation to implementation.

Asking and understanding what health professionals needed for and from clinical supervision was important. Equally important was the practical realisation of these needs as tools to facilitate conversations about future needs and implementation in any context or health organisation. The use of an interpretive philosophical framework enabled me to acknowledge the different experiences within clinical supervision and within the research framework. Using action research under a hermeneutics-based methodological umbrella enabled the deeper thinking that was required for theoretical advancement on the topic of clinical supervision, but also facilitated the practical enactment of this thinking into tools that can result in changes to clinical-supervision practice.

The findings presented in this exegesis, which are supported by documentation in the accompanying portfolio, highlight the importance of engagement with allied-health professionals in the planning and practical implementation of clinical supervision and provide practical principles and tools to accomplish it.
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POSTSCRIPT
The purpose of this brief postscript is to provide some detail of the implementation phase that followed policy development. This occurred outside of the scope and timing of the study; however, it is an interesting development relevant to the research. I aim to convey a sense of closure by answering the question of what happened next.

It was my experience following formal approval of the policy that it was well accepted across the allied-health disciplines. This acceptance was largely due to the action-research process through which the clinical-supervision policy was developed, as this process elicited barriers and questions from participants. They, in turn, managed this information through the creation of the clinical-supervision guidelines, which answered those questions. Following the health organisation’s formal approval of the policy, an allied-health implementation-leadership group was formed with the aim of ensuring that the policy was consistently implemented across allied health within the health organisation, with representation from all professions. This group served to ensure consistency in implementation and addressed any barriers or questions that arose. The group continues to the date of writing this exegesis; however, they have changed the group’s focus to planning for the future of allied-health clinical supervision, monitoring policy compliance, supporting further health-professional education and serving as a resource for allied-health leadership in the domain of clinical supervision.
References


APPENDIX 1 – SURVEY RESULTS

This appendix contains the results of the anonymous survey as presented to the action-research participants (n=113 for all questions). Questions 3 and 6 formed part of my interpretation, the results of which are discussed in the body of the exegesis. All responses are represented as both a percentage of the total responses and the number of actual responses to each question.

Question 1.

How many years have you worked in your professional field?

Number of years in allied-health profession

- 1-2 years: 10.6% (12)
- 2-4 years: 15% (17)
- 5-9 years: 24.8% (12)
- 10 years or more: 10.6% (12)
Question 2.

Do you consider you have more experience as a supervisor (one who supervises) or supervisee (one who is supervised)?

<table>
<thead>
<tr>
<th>Role within clinical supervision</th>
<th>% of responses (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor</td>
<td>37.2% (42)</td>
</tr>
<tr>
<td>Supervisee</td>
<td>41.6% (47)</td>
</tr>
<tr>
<td>Equally</td>
<td>21.2% (24)</td>
</tr>
</tbody>
</table>
Question 3. Please provide a short description of an experience you have had with clinical supervision. Your story should contain enough detail so that we can understand the situation and any issues. Describe the actions of those involved and explain what the outcome was.
Clinical Supervision in Allied Health

Please provide a short description of an experience you have had with clinical supervision. Your story should contain enough detail so that we can understand the situation and any issues. Describe the actions of those involved and explain what was the outcome.

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>answered question</td>
<td>113</td>
</tr>
<tr>
<td>skipped question</td>
<td>2</td>
</tr>
</tbody>
</table>

### Response Text

<table>
<thead>
<tr>
<th>Response</th>
<th>Text</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have had an excellent experience with clinical supervision within SESIAHS. I have worked for SESIAHS for approximately 18 months and have grown tremendously as a clinician. I feel that a large part of this is to do with my experience with supervision. My supervisor has been particularly good at challenging me to think in new ways about clients, try new assessment and treatment methods and treat children and families holistically. I have found discussing particular cases with my supervisor has been a helpful way to extend my skills.</td>
<td>Mar 31, 2010 9:33 PM</td>
</tr>
<tr>
<td>2</td>
<td>I feel that I have experienced both positive and negative experiences of supervision. I feel that my current situation is quite positive. I feel that my supervisor and myself have been able to be clear about what each of us want from supervision and that this agreement is also flexible allowing adaptation as needed. In the past I have been a participant in supervision and through the course of discussing a case became emotionally upset, to the point where I was crying. I felt that my supervisor at this time felt that this was inappropriate in supervision and on reflection feel that she did not have the capacity to cope with managing the emotional issues that can sometimes come up through our work as well as she was able to provide practical and/or theoretical guidance.</td>
<td>Mar 31, 2010 10:45 PM</td>
</tr>
<tr>
<td>3</td>
<td>I emailed the psychologist who organizes the peer supervision in neuropsychology, held at Port Kembia Hospital, and linked by video conference to people in Sydney. I asked when the 2010 schedule was commencing and received an email advising me that the supervision was only suitable for experienced clinicians. I found it patronising, especially as they didn’t bother to ask whether in fact I fit that category (I have over 20 years clinical psychology experience). I found it patronising and very off-putting.</td>
<td>Apr 1, 2010 12:51 AM</td>
</tr>
<tr>
<td>4</td>
<td>I supervise podiatry students.</td>
<td>Apr 1, 2010 1:21 AM</td>
</tr>
<tr>
<td>5</td>
<td>As a student the last portion of my 10 week clinical placement was practicing ward management. During this time, my supervisor had limited input and it allowed me to develop clinical judgement and a style of my own. Of course, everything was approved by the supervisor and feedback was provided on a daily basis. It was satisfying to see week by week how I was achieving the goals I had set for myself, without too much intervention.</td>
<td>Apr 1, 2010 2:36 AM</td>
</tr>
<tr>
<td>6</td>
<td>I had a very challenging experience last year supervising a 4th Year student. The student had failed her previous placement, and if she didn't pass this placement was at risk of completely failing her Uni degree. She had achieved remarkable results at Uni and hadn't failed any other placements apart from her acute adult hospital placement. I had to fail her at her mid-placement assessment, making the whole process quite stressful for me and for her. She appeared to have significant anxiety issues and there were a number of occasions where she would 'freeze' at the door of a patient's room before going into see them, even though we would discuss the plan thoroughly before the session. She experience significant difficulty and stress talking to other Allied Health team members, and even discussing things with me. After spending 2 weeks with her in the one clinical area, and thinking that we were making progress, I took her to see patients in another clinical area and once again she struggled. She appeared unable to think &quot;outside the box&quot; and unable to manage the quick decision making process required in the acute setting. She would forget simple aspects of assessment and treatment that we had discussed on many occasions before. In order to improve her performance and develop her skills, we worked through frameworks for how to assess and treat patients from a variety of clinical areas. I got her to research the roles of every member of an Allied Health team, and to list the reasons why she might need to refer to them. I prompted her to refer to these checklists after every occasion of service while she was documenting. I had her regularly self-evaluate and assess her progress with her learning goals. Due to my huge concerns about her readiness to graduate, I contacted the University student co-ordinator to debrief and to get some feedback. I failed the student at mid-placement, and fortunately she improved in her performance to be passed at the end of placement (with a LOT of support required during those final weeks, and ongoing meetings with the Uni)</td>
<td>Apr 1, 2010 3:39 AM</td>
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<tr>
<td>7</td>
<td>I have supervised students in their first practical experience. They have little to no knowledge of the hospital system. It is hard work, long days and tiring responsibility but well worth the effort if they can grasp an understanding of their chosen profession and are left with a desire to work hard and long into the future.</td>
<td>Apr 3, 2010 2:51 AM</td>
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<tr>
<td>8</td>
<td>We as a group did an Action Learning program which was confronting for some participants and frustrating for others. I found it interesting to be part of, but it dwindled for various reasons related to issues brought up and that they were not always relevant to everyone, and the variety of interests within the group. We have as a group also been involved in a Seachange program for the whole department, this has been much better and much more relevant to the Department as a whole. For individuals there is possibly better ways of independent counsel.</td>
<td>Apr 5, 2010 10:44 PM</td>
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<td>9</td>
<td>One year due to staff changes I ended up having five supervisors. As a result there was no continuity in my supervision and I was forced to keep adapting to the style of my supervisor which varied greatly. As a result I got to the end of the year and I didn't feel like I had developed any of my learning goals as each new supervisor chose to concentrate on different aspects of learning.</td>
<td>Apr 5, 2010 10:57 PM</td>
</tr>
<tr>
<td>10</td>
<td>Student previously failed a clinical unit (of a different specialty) and was nervous and lacked self esteem. Had to start at basic assessment then move slowly onto treatment to allow him to gain confidence. He eventually passed the clinical placement. He required a lot of one to one time.</td>
<td>Apr 6, 2010 2:29 AM</td>
</tr>
<tr>
<td>11</td>
<td>Debriefing type sessions with a social worker, externally. Unstructured. My workplace is unaware of the sessions taking place. Discuss patients - without identifying the patient - particularly any situations that I feel like sharing - if stressful - how it made me feel.</td>
<td>Apr 6, 2010 2:39 AM</td>
</tr>
<tr>
<td>12</td>
<td>A situation where there were 2 supervisors for 1 supervisee. Both supervisors were working on different agendas but one supervisor became regularly critical of the supervisee's performance. Supervisee was new to profession and insecure as a consequence. A discussion was had the outcome of which was that there would only be 1 supervisor to reduce confusion. Also communication channels were to be made much clearer so as to allow future supervisee to feel able to express any issues they may have with the supervision technique.</td>
<td>Apr 6, 2010 11:05 PM</td>
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<td>Response Text</td>
<td>Apr 7, 2010 12:42 AM</td>
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<td>13</td>
<td>Differenc in opinion between 2 clinical staff of the same discipline who disagreed on pt management. Both parties were routinely supervised by different people. Individual supervision was conducted then discussion by the 2 supervisors was held. Areas of client responsibility were defined with the 2 involved clinicians and clear lists of duties reviewed. This seemd to resolve the main problems with treatment though the 2 clinicians choose not to work closely together when possible.</td>
<td>Apr 7, 2010 5:32 AM</td>
</tr>
<tr>
<td>14</td>
<td>Providing supervision to OT with poor grammatical English and substandard report writing skills. Provided intensive supervision going through and amending/correcting supervisee's reports, providing supervisee with example reports, and educating supervisee on clinical information content required. Outcome: supervisee's report writing and grammatical skills have progressively and significantly improved over a period of a few months.</td>
<td>Apr 7, 2010 10:44 PM</td>
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<tr>
<td>15</td>
<td>I have been supervised by people of the same and different professions. I have supervised people with welfare, Social Work, Psychology and Occupational Therapy qualifications. Within the Health Service, supervision has focused on recovery based mental health work. I found have a multi-disciplinary approach to be very useful. My experience has been of one to one supervision, which I find most useful. I have also been part of care discussions with senior staff - this is also useful for specific client work (less so for overall development of my work).</td>
<td>Apr 7, 2010 10:44 PM</td>
</tr>
<tr>
<td>16</td>
<td>I have provided and received supervision during my career. I have frequently found supervision difficult to co-ordinate due to other pressing work issues. My role as a supervisor has been to students on placement.</td>
<td>Apr 8, 2010 2:48 AM</td>
</tr>
<tr>
<td>17</td>
<td>I meet with my supervisor about every 3 weeks. I work in a different location to my supervisor, and have no other team members at my site on my work days. I briefly discuss all of my cases, particularly those which have complicated issues. I enjoy reassurance that I am making the right clinical and service delivery decisions. I enjoy refreshing my knowledge about policies and procedures with difficult cases. I wish my supervisor would help me to think critically, and acknowledge my opinion, rather than give me their opinion first.</td>
<td>Apr 12, 2010 5:12 AM</td>
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<tr>
<td>18</td>
<td>Group &quot;supervision&quot;: Dynamics and personality clashes were issues. Not everybody felt comfortable to share with the group. The same people generally dominated conversation. I feel that it's important for people to have a degree of privacy and/or to feel secure with the person/people involved with supervision.</td>
<td>Apr 12, 2010 6:16 AM</td>
</tr>
<tr>
<td>19</td>
<td>My experience in clinical supervision is very good clarifying ethical issues, dilemma, conflict, forms of intervention, work issues and what resources or services around. It is through clinical supervision that issues at work were clarified and I get outside specific help. I have a positive outcome eg getting help, affirming my feelings and help me build self-esteem.</td>
<td>Apr 14, 2010 5:03 AM</td>
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<tr>
<td>20</td>
<td>Supervision of senior staff member who was unwilling to look at specific clinical issues requiring attention - belief was that the staff member was very experienced and did not require anyone to oversee clinical performance. Staff member became defiant and passively aggressive. Clear examples were discussed and staff member asked to assist in developing plan to address, but did not see any need. When potential for clinical harm through either poor attention to task or non-attention to task was discussed, supervisor made suggestions for possible remedies including additional training and mentoring. Review with clear goals and dates set; final, albeit tacit agreement reached. Unfortunately staff member moved on before situation was adequately addressed.</td>
<td>Apr 14, 2010 6:32 AM</td>
</tr>
<tr>
<td>21</td>
<td>I have worked in clinical for 25 years and in a variety of settings. In my present role I provide supervision to at least 6 staff, in a management capacity.</td>
<td>Apr 14, 2010 6:37 AM</td>
</tr>
<tr>
<td>22</td>
<td>I have given clinical supervision to staff over many years. These are monthly or bi monthly sessions reviewing work issues and performance and development needed.</td>
<td>Apr 14, 2010 7:17 AM</td>
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<tr>
<td>23</td>
<td>As a manager I have overseen supervisors role within the department.</td>
<td>Apr 14, 2010 7:18 AM</td>
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<td>Response Text</td>
<td>Apr 14, 2010 8:31 AM</td>
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<td>24</td>
<td>Supervision of a staff member attached to a community team. Issues re clarity of roles, boundaries and attitudes to patients with complex needs. Supervision discussion focussed on how to influence the culture of the team acknowledge the background and professions of all team members, achieving change in a respectful way that would not alienate key team members.</td>
<td>Apr 14, 2010 10:13 PM</td>
</tr>
<tr>
<td>25</td>
<td>Recently had to do regular performance management with a staff member. Regular supervision was not solving the issues of poor performance of duties. The performance management meant having to list all of the short coming, finding strategies to address them, and then setting dated goals to be achieved. until the dated goals were written down, there was little or no change in performance. But, once the process was formalised changes were noted quickly and were maintained.</td>
<td>Apr 14, 2010 10:21 PM</td>
</tr>
<tr>
<td>26</td>
<td>A group was generated and one meeting held. Then staff changes occurred the following month, this happened for 6 months with one meeting (3 per team) consistent with members of the previous meeting. I gain very little benefit from this period of GS</td>
<td>Apr 14, 2010 10:30 PM</td>
</tr>
<tr>
<td>27</td>
<td>Supervising AP placement students and mentoring new graduates</td>
<td>Apr 14, 2010 10:46 PM</td>
</tr>
<tr>
<td>28</td>
<td>I have found workplace coaching been very helpful, where I have regularly met up with a senior colleague and set up goals and discussing strategies to achieve them. I found it has been helpful to motivate me to achieve those goals</td>
<td>Apr 14, 2010 10:46 PM</td>
</tr>
<tr>
<td>29</td>
<td>Recipient and provider with clinical and non-clinical supervisor. Positive experience that focused on me my skills and how to improve my clinical skills. Client based as needed</td>
<td>Apr 14, 2010 10:46 PM</td>
</tr>
<tr>
<td>30</td>
<td>An experience I had as a student (supervisee) stands out. I had two supervisors on my placement, one who I felt was very effective, approachable and gave clear construct feedback and positive reinforcement. The other who gave the vibe of being ‘unavailable’, had unrealistic expectations and provided feedback that I did not feel was representative of my performance. It was also very different to that which I was receiving from my other supervisor. I asked for a meeting to be held between the 3 of us to discuss this and ended up with a positive outcome. Significant discrepancy between two supervisors on one placement can be very distressing and confusing for a student. In cases where two clinicians are supervising a student it would be useful to have a policy that directed their supervision.</td>
<td>Apr 14, 2010 10:54 PM</td>
</tr>
<tr>
<td>31</td>
<td>I was recently involved in a situation where I felt the two students I was supervising were under prepared for their practical block. It was obvious from early observations that their theoretical knowledge was not up to date. It was frustrating initially because any questions or tasks that I set for them was responded with comments along the line of ‘we did this last semester or last year therefore I can’t remember etc. At the end of the first day I had to sit down with the students and explain to them the importance of revision and constant revision. I also explained that their clinical time is wasted if when they are assessing patients they do not know what the significance of results mean and what further tests should be done based on results etc. I also informed the students that the clinical placements and their performance is assessed by myself and their lack of preparation will be noted on the assessment forms. I feel getting a reality check was important for these students as they did show improvement in knowledge and their general attitude for the rest of the placements with me.</td>
<td>Apr 14, 2010 10:58 PM</td>
</tr>
<tr>
<td>32</td>
<td>Recently there was an issue within my department where 2 staff members were unable to communicate effectively and were getting irritated with each other which was affecting patient handover. Myself and another senior staff member who has had experience and training in coaching agreed that we would each offer coaching sessions to these 2 people to assist them to develop strategies to improve their communication skills. Each person had several sessions of coaching and were able to clarify the areas of difficulty and developed strategies their patient handover process</td>
<td>Apr 14, 2010 11:08 PM</td>
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<tr>
<td>Response Text</td>
<td>Apr 14, 2010 11:23 PM</td>
<td>Apr 14, 2010 11:55 PM</td>
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<tr>
<td>33 Troubleshooting difficult clinical cases. Writing a case history and discussing my management and how this ties in with the literature and evidence-based practice. Discussing how I followed EBP and how my practice could have been improved to better patient outcomes. This was then shared with the department in our professional development session to gain feedback from other speeches.</td>
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<td>34 NC</td>
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<td>35 As a new graduate I had no formal supervision. I had some informal peer supervision from a colleague. This is still ongoing and is usually focused on discussing current cases. My manager has never provided me with any direct supervision. I have had only one performance appraisal in over 4 years in my current workplace. I have had formal supervision on a few occasions with a senior colleague from an external site over the last year - this has been while I have been in a senior position. I do not feel like I have been supported in my development of clinical and administration skills, such as quality improvement. My manager works off site and there were many times as a new graduate where I was left to cover the hospital on my own with no support, even with as little as one-two months’ experience as an adult acute therapist.</td>
<td></td>
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<tr>
<td>36 I supervise/manage a department of 6 orthoptists. Part of my role is to assist new graduate orthoptist with clinical work and in particular the management of complex orthoptic cases.</td>
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<tr>
<td>37 The majority of my experience with clinical supervision involves informal discussions about case studies, usually on an ad hoc basis. Other situations involve training after a clinical issue has arisen eg via a complaint.</td>
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<tr>
<td>38 Being in a previous position of clinical lead, and supervising 12 staff, I had no supervision of my own within my own discipline. We explored external supervision but it was not funded. We developed a peer group of 5 seniors across the region and met socially to discuss strategies. A less than ideal situation, and confidentiality could be easily overlooked.</td>
<td></td>
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<tr>
<td>39 My first SW position was in a district hospital, my supervisor came to the hospital to supervise 2 SWs. He spent the major portion of the session talking about himself and provided no opportunity or desire for me to learn from the session. He was a Level 4 and I didn’t feel that I could change the dynamics.</td>
<td></td>
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<td>40 I saw my supervisor as I had a difficult parent who had pulled out her child from our services. I saw my clinical supervisor who advised me how to correctly document the sessions and phone calls with the carer and preschool teacher in case it ever came up in court. I was able to document all the necessary information correctly and I was able to ring other members involved so that the issue was addressed in a professional manner according to our policies and procedures. Talking about the sessions and issues to my supervisor also helped provide evidence to cover myself if the issue were to arise in court. There has been no court case for this client and they have been discharged.</td>
<td></td>
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<tr>
<td>41 Only good experiences. Supervision is focused on the needs of the supervisee, adopting a similar framework to Kadushin. Dependant on issues arising, Supervisor is a clear advocate on supervisee’s behalf to management or other professionals.</td>
<td></td>
<td></td>
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<tr>
<td>42 I used to receive supervision from someone who everytime I would talk about an experience I was having she would talk about her own similar experiences. Following this I stopped having supervision with her, and when the opportunity for supervision with someone else came up I took that offer. A result of this was that I began to receive great supervision.</td>
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<td>43</td>
<td>Currently, our dept does not have a formal clinical supervision programme. I provide informal clinical supervision to my colleagues across my clinical specialties such as in the dietary management of eating disorders. A colleague sought advice on the management of an inpatient with anorexia nervosa who required tube feeding in addition to an oral diet. We discussed the challenges in managing a dietary plan to normalise weight in combination with tube feeding. Included dealing with behavioural and nutritional issues unique to this clinical area. The patient gradually improved her oral intake to achieve a safe weight gain &amp; medical stabilisation resulting in removal of the feeding tube, and transfer to an eating disorder unit.</td>
<td>Apr 15, 2010 12:56 AM</td>
</tr>
<tr>
<td>44</td>
<td>As student educator I have had lots of supervision experience with undergrads, however when new grads start here they often come to me for advice etc...an example would be new grad had queries with regards to patients condition and required a reassurance as to the correct diagnosis and management plan, this helped the new grad enormously and strengthen their clinical skills and confidence.</td>
<td>Apr 15, 2010 1:15 AM</td>
</tr>
<tr>
<td>45</td>
<td>I work as a counsellor. I regularly meet with a professional supervisor. I noticed a similarity between a few of my male clients and some very challenging behaviours of their adult children. how do I engage the family system in helping these men take back more authority and control in their domestic circumstances? It was good to have a forum with someone who I like and whose knowledge I trust.</td>
<td>Apr 15, 2010 1:22 AM</td>
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<tr>
<td>46</td>
<td>being supervised by someone who had partial understanding of my area but did not fully comprehend the issues meant that when I debriefed about cases I only received positive feedback stating 'that's great, I wouldn't have known how to do that'. I did not get enough direction or critical feedback in relation to my work.</td>
<td>Apr 15, 2010 1:28 AM</td>
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<tr>
<td>47</td>
<td>Supervision for me on the whole over the 9 yrs has been adhoc even though there was a Department Policy. More often than not Supervision was cancelled. What we call &quot;on the run supervision&quot; has developed as a great way to get supervision from colleagues willing to listen over a cup of coffee. This is actually very helpful as a way of debriefing when interactions with clients have been challenging.</td>
<td>Apr 15, 2010 1:34 AM</td>
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<tr>
<td>48</td>
<td>I am a new graduate this year and thus my main experience with clinical supervision has been as a student completely my uni degree. On the whole the supervisors at all my clinics were very helpful and willing to educate me. This involved them allowing me to assess patients, which was obviously longer in duration than their assessment would have been. They also took extended periods to explain and educate me. The best experiences I had were in clinics where a particular person was assigned the role of clinical supervisor this meant I had someone to report to and never felt particular lost. The outcome of these placements was time to really have a broad outlook on my profession, what working in it involved and what knowledge was required for me to perform well in it. Very busy clinics or clinics that no person was assigned as the supervisor resulted in me feeling lost or often left to observe, obviously this resulted in a less productive day in which a learnt less.</td>
<td>Apr 15, 2010 2:20 AM</td>
</tr>
<tr>
<td>49</td>
<td>New graduates provided with close supervision for first 3 months, after which a formal review is done to talk about issues</td>
<td>Apr 15, 2010 2:59 AM</td>
</tr>
<tr>
<td>50</td>
<td>A supervisor who is friendly and is willing to meet up in casual supervision sessions to review patients and issues.</td>
<td>Apr 15, 2010 5:19 AM</td>
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<td>51</td>
<td>xx</td>
<td>Apr 15, 2010 5:35 AM</td>
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<tr>
<td>52</td>
<td>I feel supervision can be really really positive but also negative - depending on the supervisor. As a new grad I was constantly criticised for asking questions and not knowing things so I stopped asking and then I was criticised for not asking questions. It seemed like a no win situation. I have had a lot of positive experiences with supervision as well. I think the way I was treated when I was being supervised helps me supervise others better.</td>
<td>Apr 15, 2010 9:22 PM</td>
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<td>Response Text</td>
<td>Date</td>
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<tr>
<td>53 I have accessed supervision on a regular basis through monthly meetings with a clinical mentor. I believe this gives me an opportunity to problem solve difficult cases and I feel confident to take clinical problems to this supervision without feeling inadequate that I'm not sure what to do. It helps me to reflect on what I have done and work out a direction to take for future intervention.</td>
<td>Apr 16, 2010 12:07 AM</td>
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</tr>
<tr>
<td>54 It was helpful having a guideline which outlined points for discussion and areas of performance. However, I found I had difficulty thinking of issues to talk about. I often find it uncomfortable being asked what my strengths are. My supervisor was very supportive though and helped me work through it all. The points I was unsure about, she allowed me to go away and think about them so we could discuss them at a later date.</td>
<td>Apr 16, 2010 1:38 AM</td>
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</tr>
<tr>
<td>55 I supervise new staff until they are competent to do assessments on their own. An example would include checking their keratometer and axial length measurements for cataract surgery. Once we have three measurements the same on three different patients then I would allow the new staff member to do the measurements independently. I have never had any issues that have arisen from this.</td>
<td>Apr 16, 2010 1:45 AM</td>
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</tr>
<tr>
<td>56 Experience in completing annual performance reviews, monthly clinical supervision, and managing poor performance through supervision.</td>
<td>Apr 16, 2010 1:59 AM</td>
<td></td>
</tr>
<tr>
<td>57 My experience is that it is with the supervisor of choice however has not been very structured and I sometimes feel I don't know where I'm going? Still good thought. I have supervision weekly as this is the requirements of me being a new grad.</td>
<td>Apr 16, 2010 2:00 AM</td>
<td></td>
</tr>
<tr>
<td>58 When supervised private information was disclosed to another person without my permission as a result all trust was lost in the supervisor and I requested that a new supervisor be appointed. The supervisor apologised for the disclosure and I took the matter no further.</td>
<td>Apr 16, 2010 3:47 AM</td>
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</tr>
<tr>
<td>59 Supervision of dietitians from other area health services including senior dietitians. Professional supervision of Diet Aides and student supervision.</td>
<td>Apr 16, 2010 6:07 AM</td>
<td></td>
</tr>
<tr>
<td>60 I observed a situation recently, where a supervisor did not discuss clinical and professional issues with the supervisee immediately as they developed, causing the supervisee to be quite shocked when her performance appraisal was quite critical. I learnt that performance management is a large component of supervising staff and students to optimise staff experience and learning opportunity. The staff member therefore had a very negative experience in their clinical rotation and their confidence was low afterward.</td>
<td>Apr 16, 2010 6:38 AM</td>
<td></td>
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<tr>
<td>61 nil</td>
<td>Apr 18, 2010 9:48 PM</td>
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</tr>
<tr>
<td>62 When I first began work I was allocated a supervisor and regular supervisory meetings were arranged for the first 6 months. After this time, supervision became less structured. The experience was (and continues to be) a very positive experience.</td>
<td>Apr 18, 2010 10:33 PM</td>
<td></td>
</tr>
<tr>
<td>63 I organise clinical units for our department as well as taking students in the clinical setting. I do all the interaction with the various universities, co-ordinate staff, arrange accommodation as required and orientate all units. I also take acute placement students from a number of universities - 10 -12 students each year for the last 10 yrs.</td>
<td>Apr 18, 2010 10:42 PM</td>
<td></td>
</tr>
<tr>
<td>64 Since entering SESI/HS I have not received professional clinical supervision under a Social Worker as I work as a Case Manager in the Community Service Team. I believe that this is greatly needed and should be addressed.</td>
<td>Apr 18, 2010 11:20 PM</td>
<td></td>
</tr>
<tr>
<td>65 Supervising staff member on another site. Difficulties with accessing geographically &amp; timing as both of us were part time. Moved to using video conferencing, but this is not ideal as people feel the need to meet face-to-face.</td>
<td>Apr 18, 2010 11:36 PM</td>
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<tr>
<td>66 The principle of see, do, teach seems to be most helpful.</td>
<td>Apr 18, 2010 11:46 PM</td>
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<tr>
<td>67 Colleague identified as not meeting the minimum professional standard in a particular area that became a performance management issue requiring formal tutoring over a set period of time and then re audit of the standard requirements. I was the supervisor responsible for audit education and then re audit to determine compliance with the standard.</td>
<td>Apr 19, 2010 12:19 AM</td>
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<tr>
<td>Response Text</td>
<td>Apr 19, 2010 2:30 AM</td>
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<tr>
<td>68</td>
<td>Supervisor of various students. Was supervised on re entry into the profession after some years off. I have overall supervision of the department as part of my job.</td>
<td>Apr 19, 2010 3:44 AM</td>
</tr>
<tr>
<td>69</td>
<td>In the structure that I work in most of my clinical supervision is in the form of getting a phone call with a question. Me talking it through with the staff member bringing the gear up to the ward area and then demonstrating the technique and giving warning and guidance. If appropriate the staff member demonstrating the technique back to me.</td>
<td>Apr 19, 2010 4:28 AM</td>
</tr>
<tr>
<td>70</td>
<td>Supervising students and new grads</td>
<td>Apr 19, 2010 4:36 AM</td>
</tr>
<tr>
<td>71</td>
<td></td>
<td>Apr 19, 2010 5:15 AM</td>
</tr>
<tr>
<td>72</td>
<td>Supervising first year graduates on their first acute medical ward. Graduates are given a resource folder and extensive orientation programme. A meeting is organised weekly throughout their rotation to discuss problems and ward planning.</td>
<td>Apr 19, 2010 6:13 AM</td>
</tr>
<tr>
<td>73</td>
<td>Throughout my new grad year I was initially provided with supervision and guidance as needed until I was confident in an area to perform the task independently. Since then I am aware of my abilities and only seek supervision when a new skill is required where I don't feel confident in performing unsupervised. I have always been happy with the level of supervision available.</td>
<td>Apr 19, 2010 8:31 AM</td>
</tr>
<tr>
<td>74</td>
<td>Case review with skill development practice, theoretical input and support with the interface between personal matters and the case</td>
<td>Apr 19, 2010 9:51 PM</td>
</tr>
<tr>
<td>75</td>
<td>My first job involved terrific supervision. Though all of the other staff had lost experience it was a supportive, nurturing environment that enabled me to both build my confidence and skill level. The balance between being overbearing vs supportive was very well managed. I always try to emulate that experience/dynamic when supervising myself.</td>
<td>Apr 19, 2010 11:25 PM</td>
</tr>
<tr>
<td>76</td>
<td>A patient being examined by a student becomes irate that a student is doing the assessment. It was explained that the student is being supervised at all times and has the necessary skills to perform the assessment. The assessment then continues, very closely supervised and the patient cooperates.</td>
<td>Apr 20, 2010 11:57 PM</td>
</tr>
<tr>
<td>77</td>
<td>I have been both a supervisor and supervisee. I have found as a supervisee that the experience allowed me to be more confident and learn a lot more than if I had not had the opportunity of clinical supervision. As a supervisor I have also found clinical supervision rewarding and helps critical thinking.</td>
<td>Apr 21, 2010 10:33 PM</td>
</tr>
<tr>
<td>78</td>
<td>Professional supervision has generally been informal. Opportunities to have a 'mentor' have been provided but no formal structure or content for the mentoring program was instigated. Accordingly, mentoring sessions were often less than productive.</td>
<td>Apr 21, 2010 11:11 PM</td>
</tr>
<tr>
<td>79</td>
<td>as a clinical social worker monthly supervision with my senior. This was more of a task tick off sessions where I would relay what I had done and was going to do. I would have preferred more guidance and input from my senior and did not feel I gained insight, or knowledge from the supervision.</td>
<td>Apr 21, 2010 11:30 PM</td>
</tr>
<tr>
<td>80</td>
<td>Supervised a student assessing a patient. The patient assessed and recorded the patients responses under supervision and intervention was used when needed. Results were double checked. The patient was happy and comfortable with this procedure. A discussion followed with the student re: patient condition and examination technique.</td>
<td>Apr 22, 2010 1:40 AM</td>
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<tr>
<td>81</td>
<td>Learning how to implement physiotherapy in the ICU</td>
<td>Apr 22, 2010 5:41 AM</td>
</tr>
<tr>
<td>82</td>
<td>First day on a job in an acute high intensity major hospital I was taken into a room with a ventilated baby and left to treat without any guidance as to my role in the ICU / introduction to equipment (I was in a new country). The senior physio left me for 4 hours to treat 10 very sick babies. There was NO supervision for the 4 weeks period of working in this area. This has given me a very strong base from which I like to provide supervision based on the supervisee level of knowledge AND experience + support them in ongoing basis - need to touch base regularly to review even basic clients.</td>
<td>Apr 22, 2010 8:51 AM</td>
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<tr>
<td>83</td>
<td>My experience with clinical supervision has been positive at St George Hospital. It has occurred on a regular basis and was worthwhile in content</td>
<td>Apr 22, 2010 8:51 AM</td>
</tr>
<tr>
<td>84</td>
<td>A rare treatment technique was referred for a patient in my care. In order to share this experience and challenge the staff, team members were invited to participate in this lengthy case plan. Over time, each member of the team was given the opportunity to provide the service. Discussion and evidence was provided and asked them to supply. Photos were taken, review of our procedures was done in a mentor situation as well as the team setting to explore opportunities of decisions, contingency plans and goals. Coordination with nurses and podiatrists were required, careful observation of the patient's co-morbidities was required. There was an episode of wound care when the casting needed to cease until healed. There was an episode where the patient was transferred to emergency care, intensive care and medical wards, so the cast needed removal and the condition watched until ready to proceed with the original case plan. Ultimately this was a very complex learning experience for this supervisee.</td>
<td>Apr 22, 2010 10:28 PM</td>
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<tr>
<td>85</td>
<td>A situation came to mind of a staff member who continually turned up with nothing prepared for supervision despite agreeing on completing tasks. Had to reflect and change tack as a supervisor to think are these goals the supervisee is actually empowered to take on board or are they the supervisors goals? Also were there time management issues? As a result we discussed this and set smaller goals to achieve that the supervisee set. The supervisee gained more satisfaction out of this as it was more achievable.</td>
<td>Apr 23, 2010 12:22 AM</td>
</tr>
<tr>
<td>86</td>
<td>Finding a time that suited the group.</td>
<td>Apr 27, 2010 10:03 PM</td>
</tr>
<tr>
<td>87</td>
<td>I have supervised OT students in various years. I have supervised medical students who are on a community health placement. I have supervised new staff and less experienced staff as well as staff from overseas. I have found it easier to supervise students in year 1 and 2 as community is a good base for practicing interview skills and gaining knowledge of other disciplines and their roles. It is a unique learning environment as the client has more control over their environment and decision making. Limited opportunity to supervise in the past few years due to short staffing and the extra load of nursing and medical students coming through also acting up as team leader a few times per year. Enjoy supervising other staff as it involves more detailed clinical knowledge, reflection and clinical reasoning especially in regards to complex clients or specialised equipment. Enjoy the change of supervising team members when acting up as the relationship and dynamics is very different and at times challenging.</td>
<td>Apr 28, 2010 6:22 AM</td>
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<tr>
<td>88</td>
<td>Supervising students and providing the opportunity for them to participate in the clinical environment, interact with patient, make observations and prescribe exercise based on recommendations</td>
<td>Apr 28, 2010 6:46 AM</td>
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<tr>
<td>89</td>
<td>I have supervised a large range of staff and students with varying abilities. As a clinician I rarely received/receive supervision.</td>
<td>Apr 28, 2010 10:42 PM</td>
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<tr>
<td>90</td>
<td>Supervisor had limited knowledge or experience and admitted that she knew less about clinical issues than I did. Therefore supervision decided that it was not going to be about clinical issues but more about leave issues, admin etc</td>
<td>Apr 29, 2010 1:17 AM</td>
</tr>
<tr>
<td>91</td>
<td>Development of clinical supervision policy</td>
<td>Apr 29, 2010 2:01 AM</td>
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<td>92</td>
<td>As a supervisor I was asked to address some issues with a clinician I was supervising. These issues were related to administrative tasks (namely signing timesheets, filling in leave forms), yet my role at the time was for clinical supervision. My manager had delegated the other duties to me to address as she had a poor working relationship with the clinician and acknowledged that she was not able to avoid further negative interaction. Thus, I felt that clinical supervision had crossed the line into performance management, and I see them to be two very separate things. Supervision was supposed to have been a confidential and 'safe' time for the clinician to discuss any issues with their clinical work. By introducing the performance management component, our supervision relationship was damaged, and the clinician stopped raising issues that they were concerned about. I was seen as 'management', rather than as 'clinical supervisor'.</td>
<td>Apr 29, 2010 2:40 AM</td>
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<tr>
<td>93</td>
<td>n/a</td>
<td>Apr 29, 2010 5:06 AM</td>
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<td>Response Text</td>
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<td>94  Regular, informal meeting with a designated clinical supervisor. This was a contractual agreement with some documentation required to demonstrate what was discussed, a plan of action and meeting details. We discussed clinical issues specific to my clinical area. This helped me reflect on my practice and develop goals to improve both my knowledge and skills in oncology.</td>
<td>Apr 29, 2010 5:38 AM</td>
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<tr>
<td>95  Got placed with a supervisor whom I did not interact with as effectively as other members of the department. I felt this significantly reduced the benefits I received from clinical supervision. I requested for a change of supervisor to someone else whom has experience in similar clinical areas I was working. I felt I could communicate issues and cases more comfortably and get much more out of clinical supervision.</td>
<td>Apr 29, 2010 5:57 AM</td>
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<tr>
<td>96  I have had the opportunity to utilise supervision with staff members within my team to assist with clinical skill development, performance management and general support. I see supervision as a two way process where by each person being either a supervisor or a supervisee having responsibilities for maintaining the process and keeping communication lines clear. I have found that a combination of informal supervision (being able to be asked questions/feedback without a meeting etc) and formal supervision (inclusive of documentation and linking to an annual performance appraisal) most successful. I also like to utilise modelling and the opportunity for joint treatment sessions with my team members to allow people the opportunity to visually learn and learn on the job. Generally having regular supervision, and supervision styles that can be adapted to suit individual style learning and type of communication is important.</td>
<td>Apr 29, 2010 6:42 AM</td>
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<tr>
<td>97  Junior staff discussing community client, discussing strategies and problem solving recommendations to be made. Alternative solutions discussed and trialled by junior staff.</td>
<td>Apr 29, 2010 8:14 AM</td>
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<tr>
<td>98  Supervision session fortnightly re progress of patients, discharge planning and treatment. I discussed with my supervisor re: difficult cases, ie home modifications</td>
<td>Apr 29, 2010 10:21 PM</td>
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<tr>
<td>99  I meet on a monthly basis with my clinical supervisor and clinical supervision meetings usually go for about 1 hour. We discuss my clinical progress and specific cases, as well as setting professional goals and strategies. Each month we together go over how I have progressed over the last month. My supervisor is able to mentor and guide me, and I have found that it works best if the supervision is driven by the supervisee.</td>
<td>Apr 29, 2010 11:25 PM</td>
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<tr>
<td>100 I have had one to one supervision and peer supervision. I felt the most important aspect for me was trust and confidence in supervisor and peers.</td>
<td>Apr 30, 2010 5:02 AM</td>
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<tr>
<td>101 I have had clinical supervision at my last 2 practicums in NSW health and also now, as a new employee in NSW health. My experience in clinical supervision has always been positive.</td>
<td>Apr 30, 2010 5:38 AM</td>
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<tr>
<td>102 So far my experience has always been positive.</td>
<td>May 3, 2010 10:56 PM</td>
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<tr>
<td>103 Clinical supervision was re-introduced after a number of years with no supervision. It has been extremely helpful (peer supervision and individual supervision) in managing a very difficult work environment and building professional links with other social workers and in giving a feeling of some autonomy and support from like minded people.</td>
<td>May 3, 2010 11:00 PM</td>
<td></td>
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<tr>
<td>104 Staff member finding client child case difficult due to child’s and parent behaviours. Actions: Look at child behaviours and what was behind them, looked at parent behaviour and what was behind them, looked at staff member’s role, who was the main support for and why, what is the role of the service provision. Outcome: staff gaining clarity of service role and her role in support child needs, awareness to advocate child needs and to provide separate support for parent via another worker so boundaries for parent, child and worker do not become blurred.</td>
<td>May 4, 2010 2:04 AM</td>
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<tr>
<td>105 It’s ok sometimes</td>
<td>May 4, 2010 11:47 PM</td>
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<td>Response Text</td>
<td>May 5, 2010 4:13 AM</td>
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<td>106 Supervision to me doesn't mean that my supervisor will observe/make me aware of the safety issues and policies and hazards things. S/he should have enough knowledge and experience in dealing with clients, clinical reasoning and in-depth knowledge about the whole situation. I believe I will prepare myself better when I will be supervising someone.</td>
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<td>107 Student supervision, as well as assisting other staff in managing aged care patients and issues - so 'informal' supervision</td>
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<tr>
<td>108 I had a supervisor who was new to the casemix and used my supervision session to learn about the area and for resources.</td>
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<tr>
<td>109 Providing formal clinical supervision to a social work student. This is a combination of providing formal and informal supervision to the student. In formal supervision the process of support, education and administration were undertaken with students there is a strong emphasis on connecting theory and practice. The student discusses the practical work, the skills and techniques utilised and the connections these have with both process and grand theories.</td>
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<tr>
<td>110 I have received regular formal individual clinical supervision with my supervisor on a 1-2 monthly basis. This includes supportive, educational and administrative components. I also have regular informal individual supervision with my supervisor when required and informal peer supervision with the social work team in my unit. I have also been a supervisor in the past and provided regular formal supervision to staff.</td>
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<tr>
<td>111 I found my experience as a new grad being supervised quite helpful and I looked forward to supervision. I had great rapport with my supervisor and enjoyed my time with her. She was reliable and consistent and could be trusted to follow through on what I had asked. She advocated for me and was willing to spend considerable time on helping me to achieve my goals which we had set jointly. I would hope to emulate this type of supervision style with my colleagues.</td>
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<td>112 It helps to have good clear goals and a supervisor who encourages you to push yourself.</td>
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<td>113 I had an experience where a patient had been verbally abusing me because they were frustrated with their accommodation situation. There were few to no options re alternative accommodation which made my role very difficult. I used supervision to discuss this situation and the session provided alternative ideas on how to deal with the conflict and options re accommodation that hadn't been considered. The main outcome from this was that I was provided with support and had a sounding board to voice my frustration at the situation and realise that it was a systemic issue not something I could have changed personally as a professional.</td>
<td>May 5, 2010 5:57 AM</td>
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<td>105</td>
<td>May 5, 2010 10:39 PM</td>
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<td>106</td>
<td>May 6, 2010 1:45 AM</td>
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<td>107</td>
<td>May 6, 2010 1:40 AM</td>
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<td>108</td>
<td>May 7, 2010 6:39 AM</td>
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<td>109</td>
<td>May 9, 2010 11:35 PM</td>
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<td>110</td>
<td>May 10, 2010 12:23 AM</td>
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</tbody>
</table>
Question 4.

Are you aware of any problems that exist in your area in relation to clinical supervision?

Yes: 54.0% (51)
No: 46.0% (52)
Question 5.

How do you think policy on supervision would affect your experience of supervision?

- Improve the quality: 91.2% (163)
- Decrease the quality: 8.8% (10)

Improve/Decrease quality response % (n)
Question 6. What three factors do you consider most important to the process of supervision?

Results located within exegesis.
### Clinical Supervision in Allied Health

#### What 3 factors do you consider most important to the process of supervision?

<table>
<thead>
<tr>
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<th>Response Percent</th>
<th>Response Count</th>
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<tr>
<td>1</td>
<td>100.0%</td>
<td>113</td>
</tr>
<tr>
<td>2</td>
<td>99.1%</td>
<td>112</td>
</tr>
<tr>
<td>3</td>
<td>94.7%</td>
<td>107</td>
</tr>
</tbody>
</table>

**answered question** 113

**skipped question** 2

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<thead>
<tr>
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<tbody>
<tr>
<td>1</td>
<td>Skills of supervisor</td>
<td>Mar 31, 2010 9:33 PM</td>
</tr>
<tr>
<td>2</td>
<td>Strengthening and building on practice</td>
<td>Mar 31, 2010 10:45 PM</td>
</tr>
<tr>
<td>3</td>
<td>Commitment from management by provision of set hours for supervision</td>
<td>Apr 1, 2010 12:51 AM</td>
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<tr>
<td>4</td>
<td>Support</td>
<td>Apr 1, 2010 1:21 AM</td>
</tr>
<tr>
<td>5</td>
<td>Experienced supervisors</td>
<td>Apr 1, 2010 2:26 AM</td>
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<tr>
<td>6</td>
<td>Training for supervisors</td>
<td>Apr 1, 2010 3:39 AM</td>
</tr>
<tr>
<td>7</td>
<td>Respect for the supervisor</td>
<td>Apr 3, 2010 2:51 AM</td>
</tr>
<tr>
<td>8</td>
<td>Honesty openness to freely share Nonjudgemental</td>
<td>Apr 5, 2010 10:44 PM</td>
</tr>
<tr>
<td>9</td>
<td>Consistent supervision from the same supervisor.</td>
<td>Apr 5, 2010 10:57 PM</td>
</tr>
<tr>
<td>10</td>
<td>One on one supervision of students</td>
<td>Apr 6, 2010 2:29 AM</td>
</tr>
<tr>
<td>11</td>
<td>Accessibility</td>
<td>Apr 6, 2010 2:39 AM</td>
</tr>
<tr>
<td>12</td>
<td>Ongoing support throughout career</td>
<td>Apr 6, 2010 11:05 PM</td>
</tr>
<tr>
<td>13</td>
<td>Set intervals so it occurs whether the staff member is working well or has difficulties</td>
<td>Apr 7, 2010 12:42 AM</td>
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<tr>
<td>14</td>
<td>Listening and inter-personal skills</td>
<td>Apr 7, 2010 5:32 AM</td>
</tr>
<tr>
<td>15</td>
<td>Similar overall philosophy</td>
<td>Apr 7, 2010 10:44 PM</td>
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<tr>
<td>16</td>
<td>Regularly</td>
<td>Apr 8, 2010 2:48 AM</td>
</tr>
<tr>
<td>17</td>
<td>Acknowledgement of the supervisee's skills and strategies they have already used to problem solve</td>
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<td>Structure</td>
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<td>Open channels of communication</td>
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<td>Specific time set aside for completion</td>
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<td>staff evaluations / appraisals</td>
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<td>Consistent time frames between supervision meetings - good planning!</td>
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<td>TIME - needs to be allocated</td>
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<td>Clear two way communication</td>
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<td>Professional Development/Mindfulness of practice</td>
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<td>Timely supervision - accessible, ongoing, regular</td>
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<td>Ability to identify issues</td>
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<td>67</td>
<td>understand your area of expertise</td>
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<td>68</td>
<td>communication skills</td>
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<td>Staff member feels comfortable to ask questions as they arise.</td>
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<td>Time for direct observation of supervisee within the clinical setting</td>
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<td>ask enabling questions to allow supervisee to come to the conclusion</td>
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<td>themselves based on their knowledge and experience</td>
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<td>Clinical and skill development</td>
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<td>76</td>
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<td>77</td>
<td>Continuity</td>
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<td>78</td>
<td>Appropriately targeted</td>
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<td>79</td>
<td>the time for supervision is considered sacred (ie it is not moved, shortened, interrupted etc)</td>
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<td>80</td>
<td>Constructive criticism</td>
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<td>Constructive feedback</td>
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<tr>
<td>82</td>
<td>understanding of how to identify needs / goals for any individual</td>
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<td>Making time for supervision</td>
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<td>Flexible in delivery and timing to meet individual needs</td>
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<td>experience</td>
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<td>effective communication</td>
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<td>96</td>
<td>Having the opportunity to be supported (with learning, issues etc) within a formal and documented structure.</td>
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<tr>
<td>113</td>
<td>Providing feedback on clinical interventions to enhance practice</td>
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<td>Understanding between supervisor and supervisee of the purpose of supervision meetings</td>
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<td>Opportunity for personal reflection</td>
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<td>Commitment from Management to provide individual supervision as well as peer/group supervision</td>
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<td>opportunity for the supervisee to work independently</td>
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<td>Supervisors needs to understand what the supervisee’s job entails (ideally have had experience doing that job)</td>
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<tr>
<td>7</td>
<td>communication</td>
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<td>that there is a clear process with commitment to outcomes</td>
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<td>Goal directed</td>
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<td>quality of supervisor qualification</td>
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<td>Helping supervisee to access further info needed</td>
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<td>honesty</td>
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<td>reflective practice</td>
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<td>Dedicated time for supervision unconstrained by clinical demand</td>
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<td>Clear goals</td>
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<td>clinical supervisor to read widely and to be up to date with new concepts and research in their field</td>
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<td>social skills of the supervisor, recognition of the skills and learning styles of the supervisee</td>
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<td>support</td>
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<td>Supervisor to properly ‘hear’ the concerns of the supervisee, and address these as appropriate</td>
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<td>43</td>
<td>Experience/knowledge of supervisor to conduct valuable supervision</td>
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<td>availability</td>
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<td>confidentiality</td>
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<td>support/clinical</td>
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<td>48</td>
<td>Time allocated to the person being supervised</td>
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<td>Formal evaluation after a certain period of time for new staff</td>
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<td>To be confident in the experience and professional knowledge of the supervisor</td>
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<td>Basic structure but flexibility</td>
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<td>Supportiveness of supervisor</td>
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<td>53</td>
<td>Individual to the persons needs</td>
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<td>54</td>
<td>An introduction to supervision particularly so new grads are aware of their role in supervision and so they are prepared to answer/ask questions</td>
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<tr>
<td>55</td>
<td>Good communication</td>
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<td>56</td>
<td>Interest in completing supervision and respect between supervisor and supervisee</td>
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<td>57</td>
<td>Clear Structure</td>
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<td>58</td>
<td>The wishes of the person being supervised</td>
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<td>Good working relationship between both parties</td>
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<td>60</td>
<td>Clinical reasoning</td>
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<td>Be direct</td>
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<td>62</td>
<td>Clear expectations</td>
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<td>63</td>
<td>Good relationships</td>
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<td>64</td>
<td>Debriefing</td>
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<td>Supervisor has an appropriate level of experience in the area</td>
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<td>Resources (time) to deal with them</td>
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<td>67</td>
<td>Requirements of the task</td>
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<td>68</td>
<td>Time</td>
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<td>69</td>
<td>Making it a priority setting aside the time</td>
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<tr>
<td>70</td>
<td>Understanding</td>
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<td>71</td>
<td>Honesty</td>
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<tr>
<td>72</td>
<td>Formal and informal feedback sessions on a regular basis</td>
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<td>73</td>
<td>Provide feedback to performance and possible suggestions</td>
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<td>74</td>
<td>Use of up to date theory</td>
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<td>75</td>
<td>Setting aside dedicated time to do it</td>
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<td>76</td>
<td>Having sufficient time to properly investigate and explain conditions</td>
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<td>77</td>
<td>Preparedness</td>
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<td>78</td>
<td>Formal structures and defined goals for supervisor and supervisee</td>
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<td>79</td>
<td>Both the supervisor and supervisee understand what supervision is</td>
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<td>80</td>
<td>Opportunity to ask questions/ raise issues</td>
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<td>81</td>
<td>Ability to practice skills</td>
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<td>Time allocated and dedicated for supervision</td>
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<td>Making the supervision relevant and valuable</td>
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<td>84</td>
<td>Trust</td>
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<td>85</td>
<td>Ensuring all staff are supported and able to give feedback</td>
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<td>86</td>
<td>Not having to keep minutes</td>
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<td>Reflection and critical thinking</td>
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<td>Opportunity for hands on experience with close assistance initially</td>
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<td>Consistently built into every clinical position</td>
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<td>91</td>
<td>Seen as a development opportunity</td>
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<td>92</td>
<td>Understanding of what supervision is for - ie not a dumping ground for complaints and whining</td>
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<td>Up to date knowledge</td>
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<td>94</td>
<td>Setting goals and timelines</td>
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<p>| 1 | opportunity to receive clinical feedback about practice and potential areas to build on | Mar 31, 2010 9:33 PM |
| 2 | Having sufficient qualified supervisors available - preferably without clinical responsibilities that push out the supervision | Mar 31, 2010 10:45 PM |
| 3 | education | Apr 1, 2010 12:51 AM |
| 4 | appropriate feedback from both parties | Apr 1, 2010 2:36 AM |
| 5 | Respect between supervisor &amp; supervisee | Apr 1, 2010 3:39 AM |
| 6 | willingness to learn | Apr 3, 2010 2:51 AM |
| 7 | reflection and recognition/celebrate achievements | Apr 5, 2010 10:44 PM |
| 8 | Regular case discussion and joint supervision. | Apr 5, 2010 10:57 PM |
| 9 | students come with adequate knowledge base | Apr 6, 2010 2:29 AM |
| 10 | choice of supervisors | Apr 6, 2010 2:39 AM |
| 11 | Empowerment | Apr 6, 2010 11:05 PM |
| 12 | review of those goals in timely manner | Apr 7, 2010 12:42 AM |
| 13 | Open communication and information sharing | Apr 7, 2010 5:32 AM |
| 14 | regular meetings | Apr 7, 2010 10:44 PM |
| 15 | privacy | Apr 8, 2010 2:48 AM |
| 16 | Providing opportunities for supervisee to try something new | Apr 12, 2010 5:12 AM |
| 17 | strategies for improvement/change | Apr 12, 2010 6:16 AM |
| 18 | Trust/confidentiality | Apr 14, 2010 5:03 AM |
| 19 | confidentiality | Apr 14, 2010 6:32 AM |
| 20 | Respect | Apr 14, 2010 6:37 AM |
| 21 | allowing adequate time | Apr 14, 2010 7:17 AM |
| 22 | resources and accomodation for an effective teaching environment | Apr 14, 2010 7:18 AM |
| 23 | recording sessions to identify goals and facilitate sense of achievement and moving towards what’s been planned | Apr 14, 2010 8:31 AM |</p>
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<td>View that supervision is ongoing - its a process in order to achieve something.</td>
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Question 7.

Do you think it would be helpful to have an whole of allied health approach to clinical supervision?

- Yes: 62.8% (71)
- No: 37.2% (42)

% responses
APPENDIX 2 - STUDY TIMELINE

2009
- Survey completed. Action research groups developed clinical supervision policy. Policy reviewed by all allied health professionals.

2010
- Literature Review published (Ch 3).
- Clinical supervision policy approved and published in health organisation.

2011
- Level 2, meta-interpretation commences.

2012
- Literature review submitted for publication. Policy submitted to health organisation for approval. Policy approval delayed due to organisational changes.

2013

2014
- Allied Health Key Dimensions Model developed as result of further meta-interpretation.

2015
- 3rd paper submitted (Ch 4).
- Finalise Exegesis & Portfolio and submitted.