

## National Clinical Supervision Support Framework – Consultation Draft

Organisation: Services for Australian Rural and Remote Allied Health (SARRAH)

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The National Clinical Supervision Support Framework (the Framework) has recently been developed to guide and support clinical education and training activity in the health sector. In particular, it will inform and underpin projects and activities undertaken as part of the CSSP. It aims to promote high standards of clinical supervision, to expand capacity and capability, and to cultivate public trust in health professional education and training.

### Comments on the draft Framework

Interested parties are requested to provide comments on the draft Framework to HWA by **COB 13 May 2011**. Comments should be forwarded via email to [CSSP@HWA.gov.au](mailto:CSSP@HWA.gov.au).

### Clarity

#### **Roles and responsibilities**

1. The roles and responsibilities of all participants involved in the clinical supervision process should be clearly stated, communicated, and documented as appropriate. For this purpose, participants in the process include students, clinical supervisors, managers and staff at placement sites, and those in clinical supervisor support roles who organise or coordinate placements.

SARRAH supports this principle with particular recognition that the provision of clinical supervision in rural and remote settings may be provided by clinicians from different disciplines or by supervisors located off site from the placement. The provision of such supervision will require increased preparation, training and support by all those involved in clinical placements in rural and remote communities, including the organisation, supervisors and the student.

#### **Expectations of supervisors, students, and placement sites**

2. To guide the clinical supervision process, expectations and learning objectives of clinical placements should be clearly articulated.

SARRAH supports this principle with recognition that specific aspects of rural and remote clinical placements be included as part of the expectations and learning objectives. Such expectations may include, but not be confined to: culturally safe practice, self-reflective practice, self-care, community engagement, increasing community capacity, communication skills, management skills, inter-professional practice, as well as discipline specific clinical skills.

3. To ensure health service delivery requirements are met, expectations of the clinical placement site should be clearly articulated.

SARRAH supports this principle with the inclusion of expectations regarding support from the tertiary institute from which the student originates to meet the requirements and learning outcomes of the clinical placement.

## Quality

### Patient care

4. Patient care provided during clinical placements must be safe, of high quality, appropriate and effective, and be the overriding priority.

SARRAH supports this principle.

### Clinical supervisor knowledge and skills

5. A recommended core set of knowledge, skills and attributes for clinical supervisors to deliver quality clinical supervision should be defined

SARRAH supports this principle. It is of particular importance for those providing clinical supervision in rural and remote regions where the student and supervisor may be from different professions. Clinical supervision in such areas may be provided by a number of professionals both on and off site supported by electronic communications such as telephone, email, video conferencing facilities. Effective communication, team work and organisational support for supervision provided via the above arrangements is critical to ensure that quality clinical supervision is delivered.

### Education program attributes

6. The education program underlying the clinical placement should:
  - be based on contemporary teaching methods, including role modelling and adult learning principles;
  - reflect a diversity of experience, including opportunities for inter-professional learning and exposure to non-traditional settings, where appropriate;
  - provide adequate exposure to the relevant scope of practice for the profession;
  - incorporate and support valid, reliable and established student feedback, assessment and reporting tools and processes aligned to the stated learning objectives.

SARRAH supports this principle. It must be recognised that there are also context-specific issues in terms of applying these generic principles that are both discipline specific and relative to the rurality of the practice setting. SARRAH supports the development of generic training programs coupled with more specific contextual training such as a breakout model to contextualise the larger generic training program.

### Preparation and support

7. Clinical supervision will be most effective when clinical supervisors and students are adequately prepared and supported. They should be provided with an understanding of profession specific requirements and learning objectives, clinical placement site requirements and ongoing support and access to relevant resources throughout the clinical placement experience. Ongoing support for student welfare must also be emphasised, to enhance student participation and retention.

Supervisors should have access to or be provided with training in the core set of knowledge, skills, and attributes necessary for quality clinical supervision.

Students should have access to or be provided with adequate orientation to the clinical placement setting.

SARRAH supports this principle. It is particularly important for students undertaking clinical placements in rural and remote settings and where the supervision may be provided by clinicians from a different professional background to the student. In such cases it is essential that the model of clinical placement incorporates discipline specific supervision and support for the student provided by either the tertiary institution or by some other formalised mechanism as part of the clinical placement agreement with the organisation. The provision of orientation for the student to the clinical placement setting must include cultural awareness and culturally safety in practice where working with Indigenous populations or people from other culturally diverse backgrounds.

SARRAH recognises that the University Departments of Rural Health (UDRH's), where they exist, provide excellent access to training for rural allied health professionals in all of the above mentioned competencies. SARRAH supports the continuation and expansion of the number of UDRH's and also recommends that dedicated allied health clinical academics be established at every UDRH, so inter-professionally adapted education can be provided to increase access to this important education.

## Culture

### Organisations

8. The objectives of organisations providing clinical education and training should include a strong and measurable commitment to clinical education and training, innovation and improvement.

SARRAH supports this principle. It is particularly important in rural and remote settings where the organisational corporate structure does not include allied health input.

### Resources

9. An appropriate funding and resource base will strengthen and promote the status of clinical education and training in the health sector

SARRAH supports this principle and requests that the increased costs of providing clinical placements in rural and remote settings be recognised. This includes the costs to the student, already recognised in the provision of clinical allied health placement scholarships. However, the requirement to use increased IT resources for the provision of support including videoconferencing to ensure the student gets appropriate supervision both onsite and discipline specific must also be recognised.

### Relationships

10. Clinical supervision capacity and capability and its expansion, should be supported by strong collaborative relationships among participants involved in the supervision process, including between the health and education sectors, within and across professions, and between the supervisor and the student.

SARRAH supports this principle. It has been well established that rural student placements increase the likelihood of a subsequent choice to work rurally after graduation. As such, clinical supervision of students is an essential part of all rural allied health practice.

In direct opposition to this is the fact of severe allied health workforce shortages in regional, rural and remote settings create exceptionally high clinical demands that make student supervision very difficult to manage.

A shift in organisational culture is essential to include a longer term perspective on rural health service delivery, including building stronger collaborative relationships between the health and education sectors as well as across professions.

## Learning environment

11. Clinical placements should facilitate education and learning in a safe, supportive and appropriately resourced work environment.

SARRAH strongly supports this principle. Clinical supervision support should be provided at a local level in the specific context in which the student placement is occurring. The increased costs of providing appropriate clinical supervision for students undertaking rural and remote clinical placements must be properly resourced.

## Recognition

12. Explicitly recognising clinical supervision in the workloads of health professionals will improve clinical education and training capacity and quality. While some professions have dedicated positions with clinical education and training responsibilities, other health professionals take on the clinical supervision role in addition to their usual workload. Clinical supervision should be acknowledged and valued by the health and education sector.

SARRAH recognises that the absence of dedicated allied health clinical educator positions is a major obstacle to clinical education in the allied health sector. There are severe workforce shortages in rural and remote Australia, which places increased demands on potential student supervisors' time. As a consequence there is substantial pressure to provide clinical service delivery in preference to clinical education.

Full time dedicated allied health educator positions are particularly well suited to regional settings where there is a larger concentration of infrastructure and the capacity to take greater numbers of students. In contrast, dedicated allied health educator positions would be more appropriately established on a part time basis in rural and remote settings.

SARRAH recommends that, in rural and remote settings (RA 4 & 5), dedicated clinical supervisor positions, in addition to student supervision, should include the supervision of new graduates who are isolated and required to perform a broad range of clinical services as is typical in rural practice.

## General Comments:

SARRAH welcomes the opportunity to submit comments on the Framework.

SARRAH is nationally recognised as a peak body representing rural and remote allied health professionals working in both the public and private sector.

SARRAH's representation comes from a range of allied health disciplines including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These allied health professionals provide a range of clinical and health education services to individuals who live in rural and remote communities. It is noteworthy that in many smaller and more remote communities those people in need of primary health care are reliant on nursing and allied health services.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that allied health professional services are basic and core to Australians' primary health care and wellbeing.

SARRAH is well positioned to continue to work with the Commonwealth and other stakeholders to assist in the implementation and future review of the Framework.