Professional practice support and supervision in the Territory

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Background

Evidence from the literature

There is considerable evidence in the literature that supports the implementation of professional supervision and support programs for allied health professionals (AHP). While many of the studies are small and have frequently focused on new graduates employed in rural and remote settings, anecdotal evidence from professional association papers and government documents, as well as personal communications suggest that the findings apply regardless of years of experience. Mandatory professional practice supervision for new graduates is advocated by some authors.

Numerous benefits accrue from participating in professional practice and supervision programs. Increased networking and access to resources are seen by practitioners to be incentives, in addition to enhanced clinical skill. Reduction of burnout, as well as skill acquisition and staff retention have been reported.

Significant dangers exist when support is not available. Lack of support and subsequent decreased job satisfaction can be significant for new graduates, while enhancing available support may help to retain graduates in rural positions. Supervision has been reported as a significant predictor of organisational commitment.

The literature makes clear that the role of the mentor and a professional supervision and support program is not a quasi-management strategy. The program needs to be safeguarded against such use in order to ensure that the outcomes for client care are optimal. Participants need to feel sufficient trust within the relationship to disclose their weaknesses. An effective supervision relationship includes procedures for direct observation of clinical skills, learning of new skills and the availability of detailed feedback. Formal agreements can assist participants to avoid the danger of professional supervision and support sessions degenerating into unstructured social exchanges. Differences between ‘expert’ and ‘colleague’ as mentor are delineated and both noted to play important though different roles.

The Northern Territory context

The Northern Territory government’s Department of Health & Families (DHF) is the major employer of allied health professionals in the Territory. The allied health professional workforce is a small, dispersed workforce with a strong multi-disciplinary approach to practice. There are approximately 350 allied health professionals across the Territory. Many are sole practitioners in their given discipline and have extended and overlapping roles and responsibilities within a team-based model of practice. Dispersed population, unique health issues, language and cultural barriers, seasonal travel problems, relative inexperience and small size of AHP workforce make work in the Northern Territory unique and professional practice supervision an important component of quality service delivery.

In line with its strategic directions, the Department of Health and Families recognised the need to support and equip its workforce to meet the challenges of providing services to the NT population. In response to a report from the Allied Health Professionals’ Reference Group (AHPGR) on professional practice support in late 2006, the DHF’s Strategic Workforce Committee (SWC) endorsed the development of professional practice supervision policy and procedures.

Methodology

The Professional Practice Support and Supervision (PPSS) project commenced in 2007 with the appointment of project officers, and establishment of the PPSS Reference Group. The PPSS reference group comprised of key stakeholders including representatives from allied health management, policy development, allied health professionals, human resources and quality management. The project was
allocated approximately a day per week. The Reference Group met regularly with the project officer, and the Principal Allied Health Advisor was also available for general oversight and for phone and face to face consultation at all stages of the project.

PPSS policy and guidelines were developed under the direction of the PPSS reference group. The Allied Health Professional Reference Group provided additional interprofessional guidance during the development phase. Draft guidelines were then validated through a consultation process with AHP managers and staff across the Territory. These sessions were conducted face to face in Darwin and Alice Springs and via teleconference for Gove and Katherine. Reference group members were also in attendance at these sessions to facilitate informed discussion and broker solutions to issues.

Feedback from the consultation sessions was valuable in fine-tuning the guidelines as well as identifying issues and possible solutions for successful implementation. Issues included identification, training and support of suitable mentors; workforce capacity to provide sufficient numbers of mentors and the cost-neutral design of the project. As a result of these discussions a decision was made to pilot the guidelines prior to full implementation.

Results

The PPSS policy mandates that all allied health staff are to access professional support and supervision (PPSS). The objectives underlying the policy are the provision of best practice health service delivery and optimal client outcomes, maintenance and enhancement of core discipline competencies, and enhancement of staff recruitment, retention and morale.

The guidelines define professional practice supervision and support to be ‘activities that facilitate personal and professional growth as an Allied Health Professional (AHP). Key points that are developed within the guidelines are that PPSS:

- utilises existing DHF performance management processes as the umbrella under which PPSS activities are developed
- has capacity to utilise discipline-specific credentialing processes
- emphasises a discipline-specific mentor acting in capacity of mentor/reflector rather than supervisor/manager
- reinforces the governance responsibilities of managers to ensure quality and safe practice of AHPs
- cautions that a program of professional development is not to substitute for PPSS
- will be web-based and inclusive of useful links and tools for managers and AHPs.

PPSS is not a solo activity but requires the formation of a partnership between the AHP, manager, and a discipline-specific professional support mentor. There is an emphasis on developing an ongoing relationship with the mentor through regular contact. In some instances the mentor will be an expert or senior in their field but in other circumstances they will be a peer, acting in a formal way to facilitate growth through self-reflection. It is strongly recommended that the mentor be someone other than the line manager.

PPSS may take a variety of forms and should be individualised to the AHP’s work context. Significant position papers and manuals describe the number of hours that should be ascribed to PPSS by AH professionals of varied experience levels. Within the PPSS program it is required that less experienced AHPs engage in 4 hours per month and those with more experience engage in 1 hour per month. One way that more experienced AHPs might choose to meet these requirements is by participating as mentors within the program.

The guidelines provide the necessary contracts and processes for PPSS to be negotiated, commenced and reviewed. There are also tools and links to assist participants and managers who are seeking more information.
Piloting of the guidelines is about to commence and will aim to address barriers and to fine-tune processes prior to final program rollout. Specific activities in this final stage of the PPSS project will include:

- trial of online guidelines
- establishment of mechanisms to identify potential mentors
- development of information and training for managers, mentors
- establishment of evaluation mechanism
- provision of final recommendations to the Department of Health and Families.

Finally, in developing our NT program, a national network of AHPs working on similar projects within their own jurisdictions has been established. As this national group has shared conceptual ideas, progress and barriers, common issues and outcomes have emerged. These issues included language use, achieving buy-in from managers and AHPs, and funding limitations.

Discussion

Terminology and language

In understanding the way the PPSS project developed, it is important to include a discussion of the language. Within the allied health literature and professions, the words mentoring, precepting, continuing professional development, professional supervision, clinical supervision, and workplace learning are all used. A careful examination of the literature reveals distinct differences however the subtleties of definitions depend upon the user. Different disciplines use them to mean different things.15

The word ‘mentoring’ has come into everyday common use despite its contemporary origin in business career development contexts. It has both psychosocial16 and career enhancement benefits including reduction in staff turnover, support in difficult situations, stress reduction, development of specific staff and leadership abilities, career planning, sharing of information and improving communication, building relationships.17 Contract mentoring is an adaptation of classical mentoring with formality in the organisation of the mentoring dyad.18

The use of professional supervision as a term largely arises from professional registration requirements. Generally it refers to supervision by a more experienced professional of a less experienced one. In this sense it utilises the model of ‘expert’. Clinical supervision or professional supervision doesn’t have a widely accepted definition though some authors have suggested that it is an “enabling process that allows the individual being supervised to experience professional and personal growth without penalty”.19 It is strongly recommended that professional supervision should be separated from both managerial supervision and therapeutic counselling.20

Precepting comes mainly from the professions of nursing and pharmacy. It usually means assignment of a more experienced person to a less experienced, to assist in adaptation to the workplace. It has been also been applied by some professions to the student/supervisor dyad.18

The language used in the PPSS project needed to be inclusive of the full range of allied health professions employed within the Northern Territory’s Department of Health and Families. Intentional and careful word choice was important. The PPSS program guidelines use the words ‘mentoring’, ‘professional support’ and ‘supervision’ in their widest and most generally understood sense.

Sustainability

State/territory professional support and supervision programs have been developed with similar aims ie building workforce capacity and improving recruitment and retention in rural and remote areas. The concept of providing professional support to employees is not new. However, what is critical to the success of these programs is the extent that the model is sustainable and transferable across different work and professional contexts.
PPSS programs rely on experienced practitioners to provide leadership and support to those less experienced. However, experienced AHPs are a limited resource in rural and remote areas. The introduction of PPSS has to include strategies to support the advanced practitioner workforce, otherwise, the very tool designed to assist AHPs, may prove to be an additional burden. Possible strategies may include the establishment of clinical educator positions, development of clinical leadership roles and leadership development opportunities and training.

Collaboration in the development of national best practice professional support programs for allied health professionals is critical to sustainable and quality allied health services across rural and remote Australia. Government and non government providers, universities, professional associations and grass roots organisations, like SARRAH, all have a strong commitment to ensure rural and remote allied health professionals develop and maintain practice standards and are well equipped in their roles as practice leaders and mentors. This project has seen the development of a state/territory government PPSS network. Broader stakeholder engagement would provide the opportunity to establish a national best practice approach for rural and remote practice supervision and support.

Conclusion

The NT Professional Supervision and Support Program has been developed on a strong evidence base. Policy and guidelines reflect best practice in allied health professional supervision and support. Successful implementation will require commitment of both managers and allied health practitioners and the establishment of appropriate structures and support for mentors. State and Territory collaboration has value-added to the NT project and provided an important network that will hopefully further strengthen a national approach to supporting allied health professional practice in rural and remote Australia.

REFERENCES


Presenter

Narelle Campbell has worked for the Northern Territory Clinical School, Flinders University, based in Darwin, as an allied health academic for 5 years. During this time she has also worked part time as a Speech Pathologist and Professional Practice Support project officer for the Department of Health and Community Services, Northern Territory government. Previously she has worked in both urban and rural/remote South Australia as a speech pathologist. Holding a Bachelor of Speech Pathology and a Masters of Deaf Education, Narelle’s interest areas are clinical education and health service delivery in rural and remote regions, as well as interdisciplinary learning opportunities and clinical speech pathology.