Clinical supervision for allied health staff: necessary but not sufficient

Sandra G. Leggat[1,7] MBA, MHSc, PhD, Professor Health Services Management

Bev Phillips[2] PhD, PGDipHlthSci, DipPhysio, Adjunct Associate Professor

Philippa Pearce[3] BPhty (Otago University), Post Grad Cert. Applied Gerontoloy (Flinders University), Physiotherapist

Margaret Dawson[4] BApplSci (Pod), GradDip(Pod), MBA, DPH, Subacute Ambulatory Care Manager

Debbie Schulz[5] PhysioD, MGeron, DipBus, BAppSci(Physio), Director of Community Services

Jenni Smith[6] Grad Dip Phty Research, BAppSci (Phty), Executive Director Continuing Care and Ambulatory Services/Chief Allied Health Officer

[1]Health Services Management, La Trobe University, Bundoora, Vic. 3086, Australia.
[2]La Trobe Rural Health School, La Trobe University, PO Box 199, Bendigo, Vic. 3552, Australia.
 Email: bev.phillips@latrobe.edu.au
[3]Department of Physiotherapy, Ballarat Health Services, Ballarat, Vic. 3350, Australia. Email: PhillipaP@bhs.org.au
[4]Allied Health, Ballarat Health Services, Ballarat, Vic. 3350, Australia. Email: margaretd@bhs.org.au
[5]East Grampians Health Service, Ararat, Vic. 3377, Australia. Email: debra.schulz@eghs.net.au
[6]Northern Health, Epping, Vic. 3076, Australia. Email: jenni.smith@nh.org.au
[7]Corresponding author. Email: S.Leggat@latrobe.edu.au

Abstract

Objectives. The aim of the present study was to explore the perspectives of allied health professionals on appropriate content for effective clinical supervision of staff.

Methods. A set of statements regarding clinical supervision was identified from the literature and confirmed through a Q-sort process. The final set was administered as an online survey to 437 allied health professionals working in two Australian health services.

Results. Of the 120 respondents, 82 had experienced six or more clinical supervision sessions and were included in the analysis. Respondents suggested that clinical supervision was beneficial to both staff and patients, and was distinct from line management performance monitoring and development. Curiously, some of the respondents did not agree that observation of the supervisee's clinical practice was an aspect of clinical supervision.

Conclusions. Although clinical supervision is included as a pillar of clinical governance, current practice may not be effective in addressing clinical risk. Australian health services need clear organisational policies that outline the relationship between supervisor and supervisee, the role and responsibilities of managers, the involvement of patients and the types of situations to be communicated to the line managers.

What is known about the topic? Clinical supervision for allied health professionals is an essential component of clinical governance and is aimed at ensuring safe and high-quality care. However, there is varied understanding of the relationship between clinical supervision and performance management.
What does this paper add? This paper provides the perspectives of allied health professionals who are experienced as supervisors or who have experienced supervision. The findings suggest a clear role for clinical supervision that needs to be better recognised within organisational policy and procedure.
What are the implications for practitioners? Supervisors and supervisees must remember their duty of care and ensure compliance with organisational policies in their clinical supervisory practices.

Introduction

Clinical supervision (CS) is an important aspect of clinical governance, ensuring safe, high-quality care delivery.[1] However, there is concern across many health professions that CS is not used appropriately.[2–5] Broadly defined as a framework and a process whereby a clinical practitioner (supervisee) has the opportunity to

meet regularly with an experienced colleague (supervisor) and discuss issues of relevance to their practice,[6] CS for allied health professionals has been the focus of study in recent years. The literature suggests that allied health professional practice lacks a shared view of CS and of the relationship between CS and managerial supervision or performance management.[3,7] Performance management is defined as the process that is driven by line managers to engage their staff in improving their own performance, as well as contributing to the overall performance of the organisation.[8]

Although there are many studies suggesting that CS is effective, this effectiveness tends to be measured through self-report using the Manchester Clinical Supervision Scale.[9] The scant evidence that shows that CS is associated with better patient care is largely limited to mental health nursing.[10,11] There is a need for studies that explore the effect of CS on allied health clinical outcomes and, given that there is no agreement on the appropriate content of CS sessions for allied health staff,[12] this seemed an appropriate place to start. The aim of the present study was to gather the opinions of allied health professionals with experience with CS as a supervisee and/or supervisor on the appropriate content for CS.

Methods

Drawing from the existing literature on CS, 44 items were identified that had a relationship to development of a defined content focus for CS sessions.[4,12] These items ranged from statements about the perceived outcomes of CS, such as 'CS enhances my self efficacy regarding my role and ability' and 'Patients do benefit when clinicians receive regular CS', to specific content items, such as 'During CS sessions I am able to practise newly acquired skills' and 'CS is used to monitor the supervisee's competency in practice'. The focus was on CS of staff; student supervision was not included.

Initial reliability and construct validity testing of the 44-item scale was completed using a Q-sort[13] workshop held with six clinical supervisors and three experts in the field of CS. Participants were asked to rank each of the 44 items during this workshop on a nine-point Likert scale of agreement. The freeware program PQMethod (http://schmolck.userweb.mwn.de/qmethod/downpq-win.htm; verified 20 August 2015) was used to compute intercorrelations among the different Q-sort participants. Factor analysis was completed using the principal component method, including Varimax rotation.

The results of the Q-sort analysis were used to develop an online survey that detailed a total of 38 items, 27 of which related to the content of CS, eight items related to the outcomes of CS and three items related to the understanding of CS. The allied health professionals of two public health services in Victoria (Australia) were invited to participate by the chief allied health officer in each of the sites. To ensure the views represented both metropolitan and regional allied health. one of the health services was located in a growing metropolitan area, whereas the second was located in a regional area outside a major city. Participants were asked to indicate their agreement with each of the CS statements using a five-point Likert scale ranging from 'Strongly agree' to 'Strongly disagree'. For all 38 items, Cronbach's α was an acceptable 0.735.

The study received approval from the Human Research Ethics Committees of La Trobe University and the two participating health services in 2011.

Results

Q-sort findings

There were nine Q-sort participants. The Q-sort factor analysis resulted in two factors, with a clear delineation between the type of participant loading onto each factor. The two factors explained 74% of the variance in the data. The main focus in Factor 1, which was consistent among the current clinical supervisors, was on the supervisee. In contrast, Factor 2 was consistent among the 'expert' participants and the main focus was on quality patient care and competent practice.

The distinguishing statements for Factor 1 (first three in rank order by *z* scores; $P < 0.01$) were as follows:

- Clinical supervision involves reflecting on practice.
- There are many different activities that can take place during a clinical supervision session.
- Clinical supervision sessions should be guided by the supervisee's needs at the time.

The distinguishing statements for Factor 2 (first three in rank order by *z* scores; $P < 0.05$) were:

- Clinical supervision of staff ensures best practice patient care.
- Clinical supervision involves reflecting on relationships and interactions with patients.
- Clinical supervision is used to monitor a staff member's competency in practice.

The consensus statements that do not distinguish between Factors 1 and 2 (first three in rank order by *z* scores; $P > 0.05$) were:

- Patients do benefit when clinicians receive regular clinical supervision.
- Receiving feedback (positive or negative) is an important component of clinical supervision.
- Some preparation must be done before attending a clinical supervision session.

The Q-sort analysis suggested that the CS items identified were useful for considering the content of CS sessions. The Q-sort data for the six participants who are current clinical supervisors was then included in a factor analysis to examine for intercorrelations among the 44 statements and identify possible redundancy of individual statements. This analysis resulted in the identification of six items that were similar; one of each of the similar items was eliminated from the list, resulting in a total of 38 items for the questionnaire. The final list contained three items related to their understanding of CS, eight items that explored the outcomes of CS and 27 items specifically related to the content of CS sessions.

Survey findings

The online survey was sent to 437 allied health staff and was completed by 120 respondents, for an initial response rate of 27.5%. In order to ensure that the respondents were knowledgeable about CS, we only included responses for those allied health professional who had participated in six or more CS sessions. Of

the 120 respondents, 82 (68.3%) reported six or more CS sessions, yielding 82 fully completed and usable questionnaires. The sample included 68 females, 13 males and one sex not recorded. Figure 1 highlights the discipline and the grade of the respondents, which was representative of the allied health staffing pattern of the two organisations.

Overall, the respondents indicated, with a mean ($\pm$ s.d.) score of 4.17 ± 0.64, that they generally had a good understanding of what should be included in a CS session. There was one item where the disciplines provided a different distribution in their answers. In response to 'CS involves co-treatment with the supervisor', the social work respondents were significantly more likely to disagree, the dietician respondents were more likely to indicate no opinion and the other disciplines were more likely to agree or strongly agree ($F = 2.482$; d.f. $= 8$; $P = 0.019$).

Fifty-seven respondents (70%) indicated that they had received training in CS and 50 respondents (61%) indicated that they currently provided CS to other staff. Ninety per cent of the supervisor respondents indicated that they had received training in CS. t-Test analysis was completed to compare the mean scores of the respondents who indicated that they currently provided CS with those who did not, as well as between respondents who indicated they had participated in CS training and those who had not. There were seven statements where there were differences ($P < 0.05$) between those who supervised and those who did not. The supervisor respondents were significantly more likely to agree with the following five statements: (1) 'Receiving feedback (positive or negative) is an important component of clinical supervision' ($t = 2.306$; d.f. $= 53.57$; $P = 0.025$); (2) 'During clinical supervision sessions I am able to practise newly acquired skills' ($t = 2.208$; d.f. $= 63.32$; $P = 0.031$); (3) 'The outcome of clinical supervision sessions, for example, when the supervisee is deemed to be practising in an unsafe manner, informs the need for intervention by their line manager' ($t = 2.152$; d.f. $= 57.72$; $P = 0.036$); (4) 'Clinical supervision is a formal and structured process' ($t = 3.273$; d.f. $= 56.10$; $P = 0.002$); and (5) 'Clinical supervision involves co-treatment with a supervisor' ($t = 2.935$; d.f. $= 60.22$; $P = 0.005$).

Conversely, the supervisor respondents were significantly more likely to disagree with the statements 'Line managers should not be aware of the content of clinical supervision sessions' ($t = -2.427$; d.f. $= 62.72$; $P = 0.018$) and 'It is not clear to me what should be included in a clinical supervision session' ($t = 2.339$; d.f. $= 67.54$; $P = 0.022$).

There were only two items where the responses were different between respondents with CS training and those without. The respondents with training were more likely to agree with the statement 'Clinical supervision is a formal and structured process' ($t = 4.387$; d.f. $= 41.86$; $P = 0.000$) and disagree with the statement that 'Line managers should not be aware of the content of clinical supervision sessions' ($t = -2.584$; d.f. $= 45.37$; $P = 0.013$).

As indicated in Table 1, overall the respondents indicated that CS was useful, with positive outcomes for both patients and staff.

The content items with mean values above 4 (agree or strongly agree) were considered to represent this sample's understanding of the content of CS sessions and are included in Table 2.

There was one content item, 'CS only involves one or two specific activities or tasks', that received a mean score <2 (disagree or strongly disagree; mean $\pm$ s.d. score 1.89 ± 0.74) and this is consistent with the item above with many activities comprising CS. As indicated in Table 3, there was also insufficient support for the item 'To my knowledge there are no specific models of supervision that can be used to guide CS sessions' (mean $\pm$ s.d. 2.04 ± 1.01).

There were many CS items with mean scores between 4 and 2 that were considered to represent items where this sample did not provide sufficient support for inclusion in CS sessions (Table 4).

Principal component analysis with Varimax rotation was completed, but the component transformation matrix for the six factors indicated that the relationship between two factors was moderately to highly strong (>0.30) for several of the comparisons. This suggested that the sample size was insufficient to obtain a satisfactory factor analysis result for the number of items included.
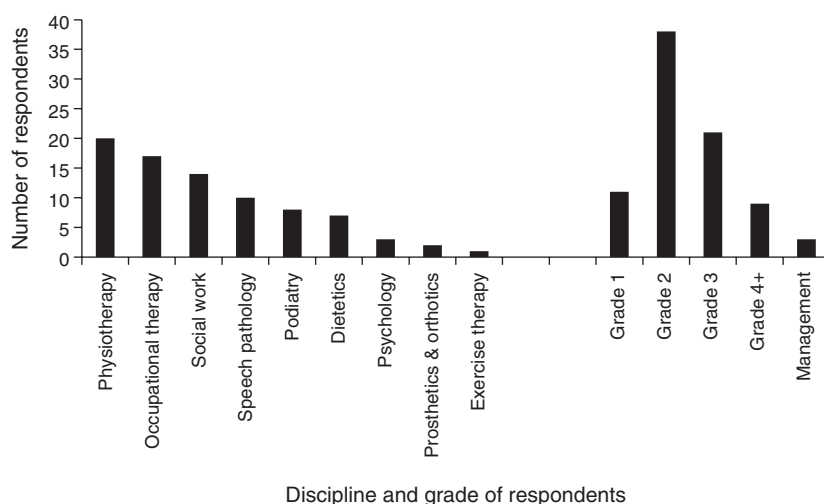

Fig. 1. Discipline and grade of the survey respondents.

Discussion

Allied health professionals of all grades and their managers were asked their opinions on CS sessions by indicating their level of agreement with 38 statements related to content, understanding and outcomes of CS. The respondents represented nine allied health professions and there was general consistency among the disciplines in their responses.

Only the item on co-treatment with the supervisor exhibited differences among the disciplines, with dietetic respondents largely indicating no opinion and social work respondents not accepting co-treatments to the same extent as other disciplines. The finding that the social work respondents were less accepting of co-treatment in CS is surprising, because there is a substantial literature in social work suggesting that supervision involves the supervisor, the social worker and the client[14] and, in fact, that supervision outcomes should be measured in relation to client outcomes.[15] However, given the nature of social work practice, further investigation is needed to evaluate whether there is a perception among social workers that including another social worker in client meetings may be difficult for their clients.

Content of clinical supervision

There was agreement that CS was beneficial for both patients and staff, which is interesting given that there is limited evidence of a positive link between CS and patient outcomes. There was also agreement that CS involved reflection, feedback, finding solutions to problems and discussion of the supervisee's career goals and personal development plans. In addition, CS should be geared to the needs of the supervisee, requires preparation before the sessions and should include a range of activities. There were seven areas where the respondents with supervisory experience had differing opinions from the respondents without this experience. The less-experienced respondents were more likely to indicate that they were not clear about the content of CS sessions, that line managers should not be aware of the content of CS sessions (and that unsafe practice should not be shared with the line manager) and that co-treatment with the supervisor was not a component of CS. The less-experienced respondents were also more likely to disagree that CS was a formal and structured process and comprised feedback and practising new skills.

The statement 'CS is used to monitor the supervisee's competency in practice' was not strongly supported. This is consistent with a previous study that has shown that allied health professionals see CS as a collegial, supportive relationship and attribute competency monitoring to the line management and performance management processes of the organisation.[4] However, growing managerialism in the public health sector[16] has seen CS afforded a strong role in ensuring the performance of health professionals,[17] which may be leading to confusion between CS and management supervision.[16,18] Even Proctor's widely used model of supervision[19] includes a normative aspect to address the performance concerns of management.[20] This 'management control' has been identified as a concern,[21] with the suggestion that '. . .supervision is at risk of becoming another technology of surveillance and becomes an opportunity to shape the practitioner into organisationally preferred ways of practice, even whilst veiled as being in the practitioner's best interests'.[22] The respondents in the present study were very clear that CS was not line performance management. Even in the Q-sort exercise, although the identified experts who have a management perspective suggested that CS was important for ensuring the competency of allied health professionals, this was not accepted by the clinicians as the purpose of CS.

Both clinical governance processes[23] and health professional duty of care[24] require escalation of unsafe practice. The respondents to the present survey did not demonstrate understanding of these expectations because the item requiring reporting of unsafe practice to line management was not strongly supported. The experienced supervisors were more likely to agree with this practice, but it is clear that if unsafe risky practice is observed through the CS process, then escalation through line management is a requirement of the supervisor. If CS is not performance management, it must operate within the organisational requirements for performance management.

'Supervisor' is a term that originated in relation to the production function in manufacturing organisations. Initially, the supervisor was seen as the day-to-day contact who made sure that

Table 1. Outcome items in rank order by mean (± s.d.) scores
CS, clinical supervision

Item	Score
CS ensures best practice patient care	4.28 ± 0.65
Regular CS helps to avoid burn-out	4.20 ± 0.68
Patients benefit when clinicians receive regular CS	4.15 ± 0.85
CS enhances my self efficacy regarding my role and ability	4.13 ± 0.52
CS helps to confirm my role as practitioner	3.94 ± 0.67
CS helps me to manage the stress associated with my work	3.72 ± 0.84
I feel less stressed after participating in CS sessions	3.45 ± 0.97
CS sessions increase my stress levels	2.13 ± 0.91

Table 2. Content items for inclusion in rank order by mean (± s.d.) scores
CS clinical supervision

Item	Score
Receiving feedback (positive or negative) is an important component of CS	4.50 ± 0.57
CS involves reflecting on practice	4.43 ± 0.52
CS involves reflecting on relationships and interactions with patients	4.34 ± 0.50
There are many different activities that can take place during a CS session	4.30 ± 0.58
CS sessions should be guided by the supervisee's needs at the time	4.18 ± 0.65
Some preparation must be done before attending a CS session	4.17 ± 0.58
CS enables me to find solutions to problems	4.15 ± 0.52
CS involves discussion regarding the supervisee's growth, personal development goals and career pathway	4.09 ± 0.79

Table 3. Understanding of CS items in rank order by mean (± s.d.) scores
CS clinical supervision

Item	Score
I have a good understanding of what should be included in CS	4.17 ± 0.64
To my knowledge there are no specific models of supervision that can be used to guide CS sessions	2.04 ± 1.01
It is not clear to me what should be included in a CS session	1.99 ± 0.84

Table 4. Content items with insufficient support to include or eliminate, in rank order by mean (± s.d.) scores
CS clinical supervision

Item	Score
CS involves reflecting on relationships and interactions with other staff	3.90 ± 0.68
CS is used to monitor the supervisee's competency in practice	3.79 ± 0.93
Reviewing and discussing case notes is an important part of CS sessions	3.68 ± 0.72
CS is a formal and structured process	3.60 ± 0.99
The outcome of CS sessions, for example, when the supervisee is deemed to be practising in an unsafe manner, informs the need for intervention by their line manager	3.50 ± 0.93
'Ad hoc' conversations with my supervisor is a form of CS	3.49 ± 1.00
CS does involve observation of a supervisee's practice	3.39 ± 1.02
CS is focused on specific tasks or activities such as reviewing case notes	3.34 ± 0.97
CS involves co-treatment with a supervisor	3.30 ± 0.93
'Ad hoc' conversations with my colleagues is a form of CS	3.27 ± 1.08
During CS sessions I am able to practise newly acquired skills	3.18 ± 0.92
CS sessions are only between supervisor and supervisee(s)	3.15 ± 1.07
Role play is used during CS sessions	2.95 ± 1.01
Resolving conflict should take place outside of CS sessions	2.85 ± 1.07
Line managers should not be aware of the content of CS sessions	2.84 ± 1.05
Tape or video recordings of treatment sessions are used for discussion during CS sessions	2.43 ± 1.07
I am not comfortable to discuss feelings and emotions during CS sessions	2.28 ± 1.01
The clinical supervisor should set the agenda for CS sessions	2.12 ± 0.66

production continued, by focusing on task allocation throughout the work processes.[25] Over time, the role of the supervisor was expanded to take on additional functions previously considered to be the responsibility of management, such as achieving the organisation's strategy and human resource management.[25] As a result, in many industries there are few differences between the roles and expectations of supervisors and managers. In allied health organisational structures, team leaders and service and department managers carry line responsibility for the management of the allied health staff. Therefore, there is no need to have clinical supervisors responsible for the same performance management functions as the line managers; CS functions should be differentiated from line management functions. Giving the clinical supervisor the function of empowering staff through reflection and feedback provides a suitable role that is different from but complements that of the line manager. It has been suggested that it is the role of the clinical supervisor to assist the supervisee with critical reflection to increase learning and improve practice.[26] Others have suggested that a performance management approach to CS will result in staff covering up performance issues instead of working with their clinical supervisor to reflect on and improve their skills.[22]

The experienced supervisors were more likely to indicate that CS comprised receiving feedback, practising newly acquired skills and co-treatment than the respondents who participated as supervisees but not supervisors. This suggests that the respondent supervisors are interested in the clinical skills of their supervisees.

However the respondents overall did not agree (mean score 3.39) that CS included observation of the supervisee's clinical practice. This was unexpected, because following training and feedback, observation was the third most common approach to CS found in a systematic review.[27] It has also been reported that the supervisory relationship with less-experienced staff tends to be more directive and is more likely to include observation of practice, but that supervision of more experienced therapists is described as collegial and cooperative,[28] with less emphasis on observation. We suggest that further study is needed to determine the role of observation of practice in CS, including consideration of the level of experience of the supervisee.

There is increasing importance ascribed to patient-focused care and partnerships with consumers,[29] and there is some evidence that patients can be effective teachers.[30] This suggests that health services should consider how service consumers could effectively participate in CS sessions, because a previous study has suggested that although patient feedback would be valued, it would be difficult to safely include in the CS processes.[6]

Limitations

The Q-sort sample included a greater number of practicing clinical supervisors, with fewer identified experts. For the survey, the sample size was insufficient for factor analysis of the questionnaire and there were small numbers for some of the professions. This reflects both the number of respondents with sufficient

CS experience and the smaller numbers of certain allied health professions in the participating organisations. As a result, the results may not be transferable to other healthcare settings, such as larger metropolitan tertiary hospitals or smaller rural settings.

Implications for safety and quality in allied health practice

Other authors have expressed concern that there is 'no single universally consensual definition of supervision within allied health'.[3] The present study begins to address this concern by providing the aggregate views of allied health professionals and their managers on the content of CS. Although previous studies have suggested that there is confusion among clinical supervisors regarding CS and line and performance management,[4,6] our respondents made the clear distinction that CS was a supportive and reflective relationship that was separate from the organisation imperatives for performance management. This is linked to a previous study that has suggested that self-reflection and self-management are important factors for the well being of professional psychologists[31] and this may apply to other allied health professions.

The respondents to the present study agreed that both the patients and the staff received benefits from CS. Our results suggest that having a CS program is necessary, but not sufficient. It was clear that the more experienced supervisors and those respondents with CS training were more likely to understand how CS was related to and supported organisational performance but, as recommended previously,[6,32] the present study reinforces the need for clear organisational policies that outline the relationship between supervisor and supervisee, the role and responsibilities of managers and the types of situations to be communicated to the managers. Although the participants of the present study generally felt positive about CS, this reinforced the need to gather empirical evidence on the effects of CS at the point of care.

Conclusions

The present study starts to address the lack of evidence for effective CS by providing the aggregate views of allied health professionals and their managers on the content of CS. The findings suggest that the current practice of CS may not be fully meeting organisational needs for clinical governance. In addition, although CS is necessary, it is not sufficiently specified and monitored in organisational policies and procedures.

Competing interests

None declared.

Acknowledgements

References

1　NHS Quality Improvement. Clinical governance & risk management: achieving safe, effective, patient-focused care and services. Scotland: NHS Quality Improvement; 2007.

2　Howatson-Jones I. Difficulties in clinical supervision and lifelong learning. *Nurs Stand* 2003; 17: 37–41. doi:10.7748/ns2003.05.17.37.37.c3398

3　Fitzpatrick S, Smith M, Wilding C. Quality allied health clinical supervision policy in Australia: a literature review. *Aust Health Rev* 2012; 36: 461–5. doi:10.1071/AH11053

4　Dawson M, Phillips B, Leggat SG. Effective clinical supervision for regional allied health professionals: the supervisee's perspective. *Aust Health Rev* 2012; 36: 92–7. doi:10.1071/AH11006

5　Snowdon DA, Millard G, Taylor NF. Effectiveness of clinical supervision of physiotherapists: a survey. *Aust Health Rev* 2015; 39: 190–6. doi:10.1071/AH14020

6　Rice F, Cullene P, McKenna H, Kelly B, Keeney S, Richey R. Clinical supervision for mental health nurses in Northern Ireland: formulating best practice guidelines. *J Psychiatr Ment Health Nurs* 2007; 14: 516–21. doi:10.1111/j.1365-2850.2007.01101.x

7　Dawson M, Phillips B, Leggat SG. Clinical supervision for allied health professionals: a systematic review. *J Allied Health* 2013; 42: 65–73.

8　Armstrong M, Baron A. Performance management. In Dransfield R, editor. Human resource management. Oxford: Heinemann; 2000. pp. 69–84.

9　Winstanley J, White E. The MCSS-26: revision of the Manchester Clinical Supervision Scale using the Rasch measurement model. *J Nurs Meas* 2011; 19: 160–78. doi:10.1891/1061-3749.19.3.160

10　Bambling M, King R, Raue P, Schweitzer R, Lambert W. Clinical supervision: its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychother Res* 2006; 16: 317–31. doi:10.1080/10503300500268524

11　Bradshaw T, Butterworth A, Mairs H. Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Ment Health Nurs* 2007; 14: 4–12.

12　Pearce P, Phillips B, Dawson M, Leggat SG. Content of clinical supervision sessions for nurses and allied health professionals: a systematic review. *Clin Govern: Int J* 2013; 18: 139–54. doi:10.1108/1477727 1311317927

13　Nahm AY, Rao SS, Solis-Galvan LE, Ragu-Nathan TS. The Q-sort method: assessing reliability and construct validity of questionnaire items at a pre-testing stage. *J Mod Appl Stat Methods* 2002; 1: 114–25.

14　Harkness D, Hensley H. Changing the focus of social work supervision: effects on client satisfaction and generalized contentment. *Soc Work* 1991; 36: 506–12.

15　Shulman L. Skills of supervision and staff management. Itasca, IL: Peacock; 1982.

16　Brunnetto Y. The impact of growing managerialism amongst professionals in Australia: a comparative study of university academics and hospital nurses. *Res Pract Human Res Manage* 2002; 10: 5–21.

17　Australian Commission on Safety and Quality in Health Care (ACSQHC). Safety and quality improvement guide standard 1: governance for safety and quality in health service organisations. Sydney: ACSQHC; 2012.

18　Yegdich T. Clinical supervision and managerial supervision: some historical and conceptual considerations. *J Adv Nurs* 1999; 30: 1195–204. doi:10.1046/j.1365-2648.1999.01189.x

19　Cutcliffe JR, Butterworth T, Proctor B, editors. Fundamental themes in clinical supervision. London: Psychology Press; 2001.

20　Long CG, Harding S, Payne K, Collins L. Nursing and health care assistant experience of supervision in a medium secure psychiatric service for women: implications for service development. *J Psychiatr Ment Health Nurs* 2014; 21: 154–62. doi:10.1111/jpm.12066

21　Cousins C. Becoming a social work supervisor: a significant role transition. *Aust Soc Work* 2004; 57: 175–85. doi:10.1111/j.1447-0748.2004.00130.x

22　Johns C. Depending on the intent and emphasis of the supervisor, clinical supervision can be a different experience. *J Nurs Manag* 2001; 9: 139–45. doi:10.1046/j.1365-2834.2001.00208.x

23 Braithwaite J, Travaglia JF. An overview of clinical governance policies, practices and initiatives. *Aust Health Rev* 2008; 32: 10–22. doi:10.1071/AH080010

24 Young A. Review: the legal duty of care for nurses and other health professionals. *J Clin Nurs* 2009; 18: 3071–8. doi:10.1111/j.1365-2702.2009.02855.x

25 Hales C. Rooted in supervision, branching into management: continuity and change in the role of first-line manager. *J Manage Stud* 2005; 42: 471–506. doi:10.1111/j.1467-6486.2005.00506.x

26 Carroll M. Supervision: critical reflection for transformational learning. *Clin Supervisor* 2010; 29: 1–19. doi:10.1080/07325221003730301

27 Milne D, Aylott H, Fitzpatrick H, Ellis MV. How does clinical supervision work? Using a "best evidence synthesis" approach to construct a basic model of supervision. *Clin Supervisor* 2008; 27: 170–90. doi:10.1080/07325220802487915

28 Bear TM, Kivlighan DM. Single-subject examination of the process of supervision of beginning and advanced supervisees. *Prof Psychol Res Pr* 1994; 25: 450–7. doi:10.1037/0735-7028.25.4.450

29 Australian Commission on Safety and Quality in Health Care (ACSQHC). National safety and quality health service standards. Sydney: ACSQHC; 2011.

30 Towle A, Bainbridge L, Godolphin W, Katz A, Kline C, Lown B, Madularu I, Solomon P, Thistlethwaite J. Active patient involvement in the education of health professionals. *Med Educ* 2010; 44: 64–74. doi:10.1111/j.1365-2923.2009.03530.x

31 Coster JS, Schwebel M. Well-functioning in professional psychologists. *Prof Psychol Res Pr* 1997; 28: 5–13. doi:10.1037/0735-7028.28.1.5

32 Strong J, Kavanagh D, Wilson J, Spence SH, Worrall L, Crow N. Supervision practice for allied health professionals within a large mental health service. *Clin Supervisor* 2008; 29: 191–210.