“The key to unlocking what’s in your head”

Clinical Supervision for Midwives – a Grounded Theory Study

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Abbreviations
CS - Clinical Supervision
N NSW LHD - Northern New South Wales Local Health District
HETI- Health Education and Training Institute
NaMO – Nursing and Midwifery Office

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Abstract

Background
Clinical supervision (CS) as reported in this study refers to facilitated, in depth, reflective practice. It has been reported to aid recruitment and retention and decrease burnout by supporting staff in their working relationships and practice.

Resources were allocated to training rural midwives in the skills of clinical supervision as a workforce planning strategy as an aid to address a predicted midwifery workforce shortage.

The aim of this study was to examine midwives experiences of clinical supervision.

Methods
A qualitative study drawing on Grounded Theory principles was conducted among Northern NSW midwives participating in CS. Midwives were interviewed about their perceptions of clinical supervision. Data was thematically analysed to explain and interpret their experiences, to generate a model grounded in this data.

Findings
The study demonstrated a dynamic interrelatedness between clinical supervision, management, midwife, team, clients and the organisation had built over time.

Additional findings revealed midwives in this study had misconceptions and lack of knowledge about reflective clinical supervision. Managers felt supported in their role when they provided staff with this place of safe reflection.

Conclusions
Midwives in NNSW LHD confirmed the benefits of clinical supervision related to support, confidence, improved interactions, and best practice. It also contributed to achieving organisational goals of greater clinician engagement, feeling supported and positive team communication.

Midwives needed education to be aware of CS and the support it could offer. Manager’s roles were augmented by incorporating CS into their workplace.

Keywords
Clinical Supervision
Midwives
Grounded Theory
Role Development Model
Reflection
Executive Summary

Background
Midwives are predicted to be in short supply in the future and are an aging population, with recruitment and retention to rural areas difficult. Resources were allocated to clinical supervision training for rural midwives by the Nursing and Midwifery Office of NSW Health to address this concern (Smith, 2008). One hundred rural midwives were trained in clinical supervision from 2008-2011.

Midwives are called upon to do psychosocial assessments in the course of caring for pregnant women. These disclosures and the intimate relationships formed during this intense time of change in women’s lives can leave midwives vulnerable to vicarious trauma (Mollart, Newing & Fourer, 2009; Mollart, Skinner, Newing & Fourer, 2013). It is a Local Health District responsibility to ensure that staff receive regular clinical supervision (PD 2010_017p37).

Clinical supervision in this context is about providing an environment where the health professional can feel safe to discuss, reflect upon and explore clinical experiences and issues. Some of the many benefits claimed in the literature surrounding clinical supervision from other countries and other disciplines included: feel supported, experience less stress, burnout and sickness absence, personal development, less inclined to leave nursing [midwifery], notice an increase in their confidence, feel less isolated, and develop their clinical competence and knowledge base (Winstanley & White, 2003; Sloan, 2005). However, there is little Australian literature about clinical supervision for midwives.

The aim of this study is to explore midwives’ of Northern NSW LHD experiences of participating in clinical supervision and generate a theory to explain its impact for rural midwives.

Approach
Semi structured interviews were used to collect data, based on grounded theory principles (Charmaz, 2010; Schnieder, Whitehead, Biondo-Wood & Harbour, 2013). Data was then used to produce a model to show how the processes of clinical supervision was approached and experienced by midwives in NNSW LHD to explain and interpret the outcomes of clinical supervision. Data collection and analysis were guided by purposeful sampling for maximum variation across areas of practice and years experience as a midwife, then theoretical sampling to pursue emerging categories. A constant comparative process and reflexivity was needed to ensure rigor and the emerging model was grounded in the data.

Findings
A model was developed. It addressed four main areas.
  
  - The core category of safe reflection was seen as the key to ‘unsramble’ what was going on in a midwife’s head. This is consistent with the existing literature and demonstrates that clinical supervision is an important support for midwives
  - There were disabling factors to getting to this place of safe reflection. Lack of knowledge or misconceptions, time and personal attributes were balanced with enabling factors of gaining knowledge and understanding the process, having an experience of it, and management providing staff support strategies.
• Benefits of engaging in CS included feeling supported, an opportunity for self care, clarity, feeling valued, increased confidence, improved team communication and relationships, and achieving best practice.

• Outcomes of midwives experiencing these benefits were consistent with achieving stated organisational goals of better team communication and the organisation ethos being focused on supporting the emotional wellbeing of staff. Well supported staff provides optimal care for their clients.

Conclusions and Recommendations

Rural NSW midwives in this study confirmed that their experiences of clinical supervision are consistent with literature about CS in other disciplines.

Additional findings show a lack of knowledge and misconceptions by midwives about CS, which leads to the recommendation to increase awareness of this support strategy. The implication for midwifery managers in having this support mechanism available is that it can augment their management role.

The recommendations for midwives’ managers are based on these findings and conclusions.

• Clinical supervision be recognised as an integral part of midwifery practice and time for CS is made available to all midwives requiring this support.

• Demystifying workshops and in-services are offered regularly to increase midwife’s and their manager’s knowledge of clinical supervision as an important workplace support.

• A comprehensive and flexible Clinical Supervision Practice Guideline be developed to fulfil the requirements of making CS available to all staff caring for families (PD 2010_17).

• The model developed in this study be recognised as a guide for implementing reflective clinical supervision for midwives by including it in the practice guideline.

• Midwifery managers across rural NSW utilize their resource of 100 trained clinical supervisors by supporting them with time and their commitment to implement this reflective practice. This would leverage the funds already spent on training.

• More staff be trained in the skills of clinical supervision to ensure adequate numbers of clinical supervisors are available.

• Reflective clinical supervision should be implemented for other areas of nursing in NNSW LHD to assist fulfil the organisational aims of improving how we communicate and how we treat each other.

• The potential for interdisciplinary CS be investigated to aid access in rural areas.
1. Introduction

A series of Nurse and Midwifery workforce forums across NSW in 2007 predicted shortages of nurses and midwives in Australia in the future and identified an aging workforce with difficulty recruiting to rural areas. Improved recruitment and retention was needed as a critical factor. Clinical supervision (CS) was nominated as a major element in providing support. Acting on feedback from the midwifery workforce forums, Clinical Supervision Consultancy was contracted to design and facilitate a schedule of clinical supervision training for midwives in rural NSW. (1)

One hundred rural midwives were trained from 2008-2011 in the model “Clinical Supervision for Role Development” (2, 3). Participants were welcomed with a note from the chief nursing and midwifery officer, stating the Nursing and Midwifery Office was committed to facilitating the implementation of clinical supervision for midwives across NSW. (see Appendix 1)

Clinical supervision is not new; it has been integrated in other disciplines such as allied health, mental health and child & family health since the mid 1980’s, however in a midwifery context in Australia it is poorly understood(4). It has been described as empathetic support for a clinician to improve knowledge and skills by offering a time and place to reflect on and develop their practice(5). Much CS literature arises from other disciplines, and internationally. There are many claims of benefits CS can generate for individuals and organisations including: staff feel more supported and experience less stress, burnout and sickness absence; develop personally and gain confidence; less inclined to leave, and develop in their clinical competence and knowledge base.(5, 6)

Midwives are required to do a psychosocial assessment and domestic violence screening with women. The process of disclosure can be emotional, as it is shared between the woman and the midwife. It requires staff working with families to exercise professional judgement and make decisions on options for care that have significant consequences for families. Studies have identified potential negative impacts that reactions experienced by the midwife can have, and the stress and vicarious trauma that may stay with the midwife.(7, 8) A recent policy requires that Local Health Districts (LHDs) are to ensure that staff receive regular clinical supervision to minimise this risk to midwives. Clinical supervision is vital to support the practitioner and maintain a professional service that focuses on the client’s needs. (9)

A regular survey conducted by NSW Health (10) identified the opportunity for improvement in how we communicate and how we treat each other. A maternity care policy (11), nominates as some key outcome measures: that staff express a high level of job satisfaction; that staff articulate a sense of pride in the achievements of the maternity unit; that staff work as a well functioning team that respect each other’s area of expertise in the normal birth process; that communication patterns are open and transparent; that staff retention rates are high, and that the organisational ethos focuses on supporting the emotional wellbeing of staff.

The midwife-perceived outcomes of clinical supervision canvassed in this study suggest that CS has a role in achieving some of these organisational goals of supporting staff emotional wellbeing, improved communication and effective teamwork. It is also suggested these outcomes may improve retention.
2. Background

Definitions and Models of Clinical Supervision

A unifying definition of clinical supervision has been elusive; this is likely in part due to the broad continuum within which the term is utilised in various disciplines. Clinical supervision in nursing and midwifery is differentiated from other forms of supervision on a continuum, from point of care supervision, facilitated professional development such as mentoring, to clinical supervision. It is recognised all variations of supervision are relevant throughout a professional career.

Since commencing this research project, a document has been launched (12) describing all the variations clinical supervision can take on, helping to differentiate what is being explored in this research as being Clinical Supervision (Reflective) and offers a succinct definition ‘Regular protected time for facilitated in depth reflection on clinical practice’. Clinical supervision is seen to offer the support necessary to sustain midwives. A more descriptive definition is offered by this researcher ‘Clinical supervision is a structured session using various techniques to explore a situation or relationship that left you feeling unsettled until you find your own way to move on.’ (13)

There are also many models of CS (14) including Proctor’s much accepted Normative,(to teach) Formative (to monitor)and Restorative (to reflect and support) model. Yegdich explores the history of CS from the early 1920’s and notes its transformation to mandatory for mental health practice (15). The allied health model is based on line management, where managers are responsible for their junior staff’s clinical supervision.(16)

Supervision of Midwives in the UK has traditionally been as a statutory governance model. In some UK services, midwifery managers are also supervisors of midwives, probably leading to supervision being viewed by some UK midwives as a policing mechanism, and can create confusion about the role and place of clinical supervision and midwives may doubt the supportive benefits it can have(17) (18, 19).

The model which rural NSW midwives were trained in is called ‘Clinical Supervision for Role Development’. The supervisee is guided to take responsibility for scrutinizing issues in their own professional practice, finding solutions from within and enhancing their own development, so that patients [clients] get the best possible care.’ (20) It is an approach developed during the 1980s by Considine(3). It is reflective, as opposed to practice-centred or problem solving and emerged from theoretical frameworks grounded in mental health.

One of many techniques used in this model is ‘The Play of Life’ (21, 22). It utilises a board, or ‘stage’. Small figures are placed by the supervisee on the ‘stage’ to represent a specific situation, a technique that engages the creative parts of the brain. It gives a three dimensional view allowing a situation to be viewed from all perspectives and often sparks some new insight. (20) The ‘Play of Life’ technique is used to represent the grounded theory model of the processes and outcomes associated with Clinical Supervision for midwives which is the subject of this report.

Literature Review

The Clinical Information Access Portal (CIAP) was used in consultation with a skilled librarian to search the journal literature in May and June 2012. The key words used were: midwives; midwifery; Clinical Supervision; reflective practice; Australia/n. During the period of this research further articles were added to these data bases. Analysis of the current literature was not attended at this stage, consistent with grounded theory principles.(23). The data should be derived from the
participants prior to engaging with the literature to ensure the findings come from the participants. The literature is then used as another source of data.

A paucity of articles were found in the Australian midwifery literature. There were many articles from the UK about CS in midwifery and nursing (19, 24-27), and in mental health and general nursing settings in various countries including Australia. (5, 28-32)

Literature from a mental health perspective suggests best-practice clinical supervision benefits not only staff, but also has significant positive implications, including financial, for organisations, with staff turnover being reduced and morale increasing. Research on CS in mental health is demonstrating what practitioners have believed anecdotally that competent clinical supervision also benefits mental health clients (31).

The literature generally agreed reflective CS was a good thing. There was little research into reflective models of clinical supervision pertaining to midwifery practice in Australia to compare with available reported experiences. The impact the introduction of the clinical supervision training for rural midwives and the implementation of this support had for midwives had not been evaluated.

Aim

This study aims to examine midwives experiences of participating in clinical supervision in NNSW LHD. Are the experiences of rural midwives of NNSW reflected in the existing research about clinical supervision?

3. Method

Study Design

As a novice researcher, the lead investigator’s view is as a relativist. Information and knowledge is based on individuals’ interpretation at any given time. There is no one truth; it is a socially constructed interpretation. Clinical supervision is also consistent with this view, as each individual’s experience is an interpretation of a situation or relationship. In consultation with an experienced researcher and mentor, (33) a qualitative study was designed using Grounded Theory principles which are consistent with a relativist perspective (23, 34).

As there was limited literature available in the Australian context for clinical supervision for midwives, using Grounded Theory principles aims to get insight into the impact CS has for midwives in their own words. One on one interviews were conducted with those who had participated in CS, to get a deep understanding of the CS experience of midwives and yield a fresh model which might explain how they engage with CS and what facilitates or stands in the way of this, and the outcomes this process may generate.

The Researchers

The coordinating investigator is a novice researcher, who is a Clinical Midwifery Specialist in a large hospital in NNSW LHD, and provider of clinical supervision for midwives in a variety of settings in the LHD. The researcher, therefore holds an ‘inside perspective’ as a CS provider. An ‘outside perspective’ has been introduced in two ways. First by choosing a mentor who is, a senior researcher, employed by Southern Cross University and seconded to the LHD as ‘an outsider’, not previously know to the lead investigator or the participants for this study, and second by employing double coding on the transcripts with the mentor.
As an insider involved in giving and receiving CS, reflexivity was needed to heighten awareness of the researcher’s own subjectivity. Grounded Theory principles accepts that researchers enter into the researched world and experiences may be shared but meanings belong to the participants. Vigilance is required to ensure the viewpoints are those of the participant. Tacit understandings of a shared world needed to be put aside by the researcher and detailed explanation of the midwives’ own perspective was clarified and recorded as data. The researcher needed to be constantly aware of personal assumptions and practice reflexivity, this improved over the process of the interviewing and transcription, and with mentor feedback.

The Participants

A survey was distributed in early 2013, aiming to get a baseline overview of midwives’ knowledge and understanding of this form of CS. The survey forms the base for ongoing investigation of CS in the NNSW LHD, and fulfils requirements of a recommendation to put this work forward as a quality activity. The survey tool is attached as is a report with selected results of this baseline survey. The subject of this report is not the survey and it is included as appendices only to aid discussion.

The Northern New South Wales Local Health District is situated across both a rural and coastal setting close to the NSW and QLD borders on the East Coast of Australia. It has six maternity units providing a variety of birthing services including antenatal and postnatal care only, standalone birthing units for normal risk pregnancy, and also larger centres which cater for all risk pregnancies but refer on to tertiary hospitals any complex pregnancies prior to 33-34 week gestation.

The LHD had 225 midwives working across the six birthing services at the time of survey distribution. Of the 225 surveys distributed, a total of 118 were returned. Respondents to the survey were asked if they would be interested in being involved in an interview to enhance understanding of the impact of CS for midwives. Twenty-six midwives agreed to be interviewed. Twelve interviews took place.

Interviewees were purposefully chosen for maximum variation across the district to involve midwives from a range of settings. Included were midwives from clinical practice, education and management. Some participants worked in hospital settings, whilst others were caseload-based. Casual, part time and full time employed midwives were all included. Maximum variation of those involved in CS was achieved across the LHD. Clinical experience ranged from one year to more than thirty years. Numbers from each category are not included as this was considered to make data too identifiable. All participants had an experience of at least three CS sessions. Midwives who had not been involved in CS were not included as the questions were about the impact CS has had for them. As themes developed more theoretic sampling was employed such as non-engagement and management perspectives.

Data saturation had been reached after twelve interviews, it was not necessary to interview the remaining fourteen midwives who agreed to be involved, however all remained available and no interviews were declined. All participants were interviewed by the lead investigator. Some also had experience of being clinical supervisors themselves. Some had received CS from other parties within the LHD. None of the participants to the interview study had a reporting line to the lead investigator, but seven midwives had received CS from the lead investigator.
Interviews

Audio recordings of interviews using a digital recording device were the primary source of data. The researcher’s memos from the interviews were taken into consideration for subsequent interviews, by employing a more conversational style and adding an opportunity to discuss a CS session that impacted them. The first group of eight midwives were interviewed early in 2013. These took place in a variety of locations of the participant’s choosing including the researcher’s home office, the participant’s office, meeting rooms at various hospitals and birth suites. The interviews took between 25 and 68 minutes and were conducted in confidentiality with no one else present.

Semi structured interviews were conducted based on an interview schedule previously used for a report on CS in Justice Health(37), with an opening question asking the midwife: “In your own words, what is clinical supervision?” (see Appendix 5 for the Interview Schedule) Discussion was stimulated and further directed the interview. The interviews took on a conversational form ending by asking the participant if there was any other information they wanted to share. The transcripts were not returned, all participants agreed to future interviews and to be contacted if any clarification was needed.

It was thought data saturation was reached after eight interviews. The model as it developed through various iterations, (see Appendix 7) was taken to new participants for validation. Interviews were conducted with four more midwives in the latter part of 2013, giving the opportunity for more perspective to be gained and a greater number of midwives to be involved. Second interviews with original participants were not conducted.

Data Analysis

The first three interviews were transcribed by the lead investigator, and then a transcription service was utilised for four more interviews which expedited the coding process as the transcriptions were then available for double coding with the mentor. Subsequent interviews were transcribed by the researcher. Constant comparison was aided by transcribing and awareness of the impact it has as the first level of data analysis was aided. During the process, codes and categories were able to be identified(38, 39). The transcripts were double spaced and each line numbered in Microsoft Word to aid thematic analysis.

Open coding with the researcher and mentor who were blinded to each other was done on the first group of interviews and then discussed. Key codes were identified and grouped into categories (see Appendix 6 for an example). These categories were sorted into higher levels of abstraction, so that a draft theory began to emerge. Memoing of thoughts and discussion with mentor helped to ensure the rigor and constant attention to personal perspectives. Codes were inductive and came from the data.

The validation process of taking iterations of the model to the participants revealed a new concept relating to CS and managers of midwives and further interviews were conducted and constant comparison of the previous interviews looking for evidence of this new category was employed. Theoretical sampling was used at this point to follow up on this category,(36, 39) locating cases for specific purposes. In grounded theory, this step strengthens the study design’s handling of subjectivity, as the participants have the opportunity to have input into the theory as it arises.

Comparative analysis of the interview transcripts, with reference to the current literature, was attended after initial coding, as is the practice with grounded theory principles.
Appendix three has a Selected Results Report of the Survey of NNSW LHD midwives about clinical supervision and is used as another source of data for discussion of the grounded theory arising from the qualitative data collection process described above.

**Ethics**

The study Clinical Supervision for Midwives: a mixed method evaluation was approved by NC NSW HREC on the 9th Nov 2012 LNR 040, with Site Specific Assessments approved on 21st Dec 2012.

**Conflict of Interest**

No conflict of interest is declared.

4. Findings

The first iteration of the model of clinical supervision for midwives was one directional, and did not consider the interactions and the organisational aspects involved (see Appendix 7). The second iteration was isolated and focused on a specific aspect, but it utilized the feedback from participants to present it using the Play of Life techniques familiar to them and a technique of the Clinical Supervision for Role Development Model described earlier.

The ensuing versions incorporated the dynamic interrelatedness of factors that build over time and lead to achieving organizational goals of greater clinician engagement and support and positive team communication leading to better client outcomes.

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**Figure 1 Safe Reflection: The key to successful Clinical Supervision implementation for midwives.**
The Model has four elements each with their own subcategories. To understand the impact of clinical supervision for these midwives the model will be discussed from the middle and the nature of safe reflection will be described, the disablers and enablers on the left to get to this place will be considered, and then an interpretation of the benefits and outcomes on the right will be explained.

**Safe Reflection**

The core category in the model is safe reflection. It is depicted as a group but could also be a one on one session. All midwives interviewed were participants in clinical supervision. They were asked what clinical supervision meant to them. Many described it as an opportunity; a place of safety to reflect and ‘unsccramble’ what was in their head. By starting with this question it clarified what was being discussed and acknowledges the potential confusion related to the name.(32, 40)

Safe reflection in the model is bounded by a green hexagonal enclosure made up of the subcategories; formal, confidential, credible, boundaries, reflection, trust, safe and objective. These are consistent with many texts and articles that describe CS (14, 28) and have been discussed here from study participant’s perspectives as interrelated concepts.

**Formal, Confidential, Boundaries**

By engaging in regular sessions, through the use of a formal written contract and through the reiteration of confidentiality, participants described their commitment to CS. A formal contract stating when, where, and how sessions will be conducted including a mention of confidentiality is a consistent theme in the literature (6, 14, 28). Confidentiality is mentioned in all descriptions of CS and was tested over time. It was one of the main aspects of a midwives’ perception of feeling safe.

M4 - ...formal contracted supervision, generally it seems to be about once a month for an hour, and, because I find the benefits of supervision I stay really well committed to that. If I say I am going to do it once a month then I will work my workload around it so I can actually attend. [...] (Midwife 4)

M1- this is confidential what you say here, and knowing that what we have discussed all year hasn’t been... I’ve never heard that it has ever gone out of that group. ‘Cause once you’ve set those boundaries at the start of every meeting, which [Name] does... I think that’s also a good and positive thing that says well I can talk about anything and that’s OK.

Some midwives interviewed discussed how groups established boundaries at the start, and also the sessions had structure and boundaries about topics, there was only ever a professional contract about workplace issues. They also discussed boundaries about standards, safety and ethical issues and the supervisee was reminded of the supervisor’s obligation to this at the start of each session.(20)

M5.-Setting the group rules at the start, some of the group rules were [...] ...that was good. I think that was a good idea... safe.... And everybody wanted the same kind of rules.

M4- when we first started these sessions; one of the things we discussed was clinical practice and safety standards.
**Credible, Objective, Trust**

Participants noted that a supervisor had to be trained in the skills of clinical supervision and have credibility in their own practice. Educational preparation of supervisors is noted and authors discuss that without adequate training of supervisors there could be risks to CS implementation (5, 41).

An objective point of view was important to participants, as were supervisor qualities of neutrality; openness, reassurance and confidentiality to forming a trusting, safe place for reflection. These are important attributes when beginning the supervisory relationship(6). The participants felt a supervisor’s personal qualities were involved in developing trust and it was noted this was a process that took time.

M10- And also [Supervisor's name] is very neutral, very UN [United Nations] like.... [] we want to be able to be really vulnerable with [Supervisor’s name], talk about you know, like our inadequacies or fears or whatever but we don’t want to hear them from anybody else. And that’s [maintaining confidentiality] how [Supervisor’s name] created the trust.

**Safe**

Midwives described feeling safe to have those in depth moments of self discovery when the above elements were in place. The opposite of trust or safety is described in a UK study where CS was offered as a possible support for UK midwives against a background of statutory supervision by managers or appointed Supervisors of Midwives. Midwives involved in this process felt it could be a policing mechanism or punitive (18, 19).

M6 - ...can express concerns and you know, ask for help without being judged on what you’re asking for help about. So there’s definitely that feeling of um, yeah- it is a feeling of safety, yeah, I think ‘safety’ is the word. Feeling safe to express.....

M9-- Oh... [Sighing...hesitant]. I think it is partly the safety. Feeling safe. And after a while you know that it is confidential, and you sort of trust that.

**Reflection**

It is generally agreed that reflection is a good thing and something midwives should incorporate into their practice as described in the Australian National Competency Standards for the Midwife under Reflective and Ethical practice (42). The midwives described using CS as an opportunity for reflection in action to adjust their behaviour.

M4- CS helped me to get to the point where I was reflecting on my part in what was going on, and then I was able to change my part in what was happening to move the dynamics on.

The core category described as safe reflection in the model demonstrated the interrelatedness of the subcategories as described by the midwives. The model aimed to give the impression of a green safety barrier as the enclosure around a group with a key between them to depict this is the key to safe reflection; a concept that resonated with the midwife participants as the model developed.
Disablers and Enablers

Participants agreed the path to the opportunity for safe reflection was not direct. The broken purple line in the model (see Figure 3) symbolises the struggle midwives faced to get through or around the many barriers to safe reflection, demonstrated in the model as blocks with various objects on them with a questioning person behind them. The disablers will be discussed and balanced with the enabling factors of participation in clinical supervision. One of the first barriers was a lack of knowledge of CS.

**Knowledge deficit**

Represented in the model as an empty basket; is knowledge deficit. Lack of knowledge is also consistent with this researcher’s first experience of CS, totally unaware of this type of support prior to receiving training in clinical supervision.

*M5* - *But yeah, but like I never had even heard of it before, clinical supervision - it sounded kinda scary even, thinking that it was something that... you know... only happened if something was wrong, I didn’t see it as a positive thing. I didn’t know what it was.*

The total lack of knowledge or understanding of the concept that was often voiced by participants, is absent in other literature. Authors(5) use multiple definitions, and the assumption is that those doing CS will know what to expect from that meaning. In the findings of White et al, (28) reporting on the ‘lived experience ’ of CS, although the term was novel the activities associated with it were understood by participants. Conversely to this, the experience of midwives in this study was of a total lack of knowledge of the concept of being provided time out to reflect.

*M10* - *the very first session, I thought it was amazing that the health department offered it, and I felt like it really was a way to support my practise...*

It is apparent that some knowledge of reflective clinical supervision is an enabler to the process. Much of the literature is from mental health where CS is well established and utilised. Those that knew someone in, or had a mental health background themselves were open to CS. In a recent study about implementing clinical supervision for Australian rural nurses, it was also found mental health knowledge helpful to inform rural nurses. (43)

*M11* - *I knew about clinical supervision for many years [...] because in mental health they have to do clinical supervision... I was just prepared to give it a go, ‘cause I couldn’t know at first, except what I had heard from [name] knowing that everybody loves it so that’s a good way to start.*

The midwives interviewed described other enablers as education or demystifying or simply talking about CS or raising awareness, represented in the model (see figure 3) as the process facilitator. The selected survey results (see Appendix 3) show the most information gained was through direct communication with midwives such as notices, in-services or by having
clinical supervision.

  M2...the perception of what Clinical Supervision is I think has shifted quite a bit, on the unit. And I think generally around the hospitals because, people are talking more about it. ... [Name] marketing it and pursued it and kept going.

Advertising or promotional material heightened awareness.

  M10- We then went to them [managers] and said, “Can we have this? We’ve seen the flyer”

  Being encouraged to, or having an experience was helpful to demystify and had the follow on effect that once a person had an experience of CS they became encouragers or enablers to others accessing CS.

  M6- actually my first advice was to go and see a clinical supervisor to discuss it to look at strategies, ways of dealing with it

  Some midwives having had an experience of CS and decided it wasn’t suitable for them, however thought that it was beneficial, and still encouraged others to participate.

  M8- ... it’s nice to know they can go talk about whatever it is that they’re having their problems with. So that’s nice to know that it’s [CS] there.

**Misconceptions**

The furry ball in the model represents the confusion; misconceptions and misnomer surrounding CS (see Figure 3). To many of the midwives interviewed clinical supervision traditionally meant observation of clinical skills and work place performance. The name can cause confusion, when broken down into clinical and supervision can mean all of those things. Together those same two words clinical supervision, have a long history in the literature(44), particularly in mental health nursing, as a supportive function for all staff. White et al (28) during in depth interviews revealed that participants had considerable concerns about the term clinical supervision as the midwives in these interviews also describe.

  M4- ...in those days, [early 1980’s] supervision meant somebody was scrutinizing how you did technical things...

  Language and words can have different meanings at different times; (45) for example in the maternity context to ‘section’ someone can indicate a form of child birth as in ‘caesarean section’ in mental health to ‘section’ someone refers to a part of the mental health act.

  M6- well, it’s not a barrier for me now because I know the two things are different, and I suppose I now use, you know ‘clinical facilitation’ or ‘facilitating learning’ or ‘educating’ in that sense and this is clinical supervision meaning...reflective practice. (Laughs) You see now I’m used to it, I can’t imagine it being [called] anything else.

  Since commencing this research project, a document has been launched (12) describing all the variations supervision can take, helping to differentiate what is being explored in this research as being Clinical Supervision (Reflective). Over time this document may further improve midwives knowledge of this support and clarify some misunderstandings in the future.
Attributes

The wooden block and line up of various shapes represents the characteristics the participants reported can cause resistance, blocks or barriers to CS. These include personal characteristics such as self doubt, values, and priorities, characteristics of the Role Development Model itself, and supervisors’ and individual’s attitudes. It was perceived some midwives prioritised their clients over themselves.

M10 - their [other midwives] work ethic kind of tells them it’s more important to be with their patients,

Personal characteristic and values could be a disabler.

M1- ... -and I say that because I was reluctant to do it initially because... (shrugs) Because that was the way I was brought up. It’s just your lot ...you just move on and you just deal with things and you just get on with it. I was just reluctant to do it. That sitting down and talking one on one, but after doing a few sessions I thought ... WOW these are really good really, really valuable.

Characteristics of the model were perceived by some as a barrier.

M3-... do you always have to use the ‘dolls’? I know that freaks some people out.

For others it was seen as enabling:

M12... it was good to use the characters. It was as if I was talking about someone else and that separated it from me and made it possible for me to speak.

Supervisor characteristics were important enablers as the midwives described. Some of these were also noted by Winstanley et al. (5); being approachable, willing to negotiate and showing interest.

M10- I think [CS name] should work for the UN [united nations]! (Laughing) ...so compassionate and diplomatic but I guess the connection for us is that [name] is gentle with us ... safe with us... confident with us... noncritical which is really important.

Time

All participants mentioned time as an issue, represented in the model as the watch on a block (see Figure 3). Time concerns were also true in much of the literature (19, 32, 43, 46) especially in relation to staff working in acute settings as compared to community settings, where they could make appointments and keep them, or managers were able to schedule into their day. Time was the most mentioned barrier to access reported in the survey results (see Appendix 3).

M5----the difficulty is around relieving staff, you know, it’s that practical issue about getting staff off the roster to attend. I’m aware of you know, when supervision is available, and the ward’s busy, or birthing suite’s busy- that takes precedence over supervision. So there’s not— there hasn’t been a process I would think that’s been put into place that allows that to happen, every single time.

To get around this time barrier one site used a backfill plan, another plan was to have it outside of work time and utilised time in lieu:

M1- if it’s done in the right way and there is someone to cover for them,

M3 - If you really need to have some CS ...you’d find it... you’d make time.
Another concept around time was that the benefits of CS developed over time and it generally took a few sessions to work out what to do with the time. Time taken to develop skills has been noted in other studies where it took almost six months for participants to grasp the concept(43).

M2- once we’d had a few sessions and there was an incident or something that happened I felt it was a safe forum, to be able to reflect on the incidents or the people that were involved and see what my role was in it. Was it...Could I have done something different?

M9- it was interesting because we got to trial out lots of different um.... formats for working in a group in CS and I think as we got used to it I think we opened up more so....

In the survey results (see Appendix 3), the relationship between session frequency with self-reported effects indicated that greater session frequency was strongly related to greater effect in the clinical, non-clinical, personal and situational response domains.

There were some suggestions that by making CS a mandatory practice, time would be found. A 2010 a policy statement declared LHDs should ensure all staff working with families receive regular clinical supervision, applicable to many areas including maternity services(9).

M11- It is like Baby Friendly [a breast feeding policy directive], like its mandatory full stop, you just roster people and you just go for it; it’s just not that hard. But it is for some people ‘cause they have a different mindset about what’s important I guess.

M4-...that’s where I’d like to see it fit, as core business, as an expectation, as part of your everyday work, that it’s just something that happens like report writing does, and handover and all the rest. I place that sort of value on it.

Participants acknowledged that overarching the process was a management team who were committed to staff well being; depicted in the model as a person elevated on a stand with a big heart (Figure 3). Midwives described a manager’s belief in their service as critical to making CS accessible.

M10- It’s just our manager, she always seeks out ways to support us and it really was [Director of Nursing] that believed that every person at [...] should have access to clinical supervision.

M7- We have support of MUM [Midwifery Unit manager] and NaMO [Nursing and Midwifery Office] and of policy so on all levels.

If management was perceived by midwives to be unsupportive this validates this concept as was described in a setting struggling to find time, or to implement CS stated:

M8- well I mean it’s all talk, they [managers] don’t do anything to help us. Honestly I really don’t think that they have a good handle on what it’s all about. ...it’s really frustrating, it’s not a priority I don’t think, they will say things, but when it comes to doing it, it’s different.

The dotted purple line in the model symbolises the way around, through or over the blocks to assist the midwife to the safe reflection space. The disablers of knowledge deficit and misconceptions were overcome by education and experience. Creative strategies around time made
CS more available in some places and awareness of personal characteristics and attributes and management belief in CS was seen as enabling for midwives in this study.

**Benefits**

From the place of safe reflection, midwives expressed they experienced a variety of benefits including feeling supported and valued, and gains in confidence, team relationships and communication improved and opportunity for self care. These are similar to those reported by Sloan (6) and White (14). Several articles about work related stress and burnout (8, 47, 48) in midwives in Australia have suggested that CS could be a means to support midwives. The findings from this research also include many of those elements and provide a grounded model of how this support occurs and can be implemented. The green lines in the model coming out of the boundaries of safe reflection are double ended and some curled to represent it is not necessarily a direct path. They developed over time as confidence in the process developed.

**Self Care**

Taking a moment for themselves was a novel idea to most midwives, and though they recognised the importance to their well being in achieving this, many did not have a regular self care strategy. Self care is represented by a heart in the model (see Figure 4). The implementation of CS gave them a defined place to look after their own emotional well being.

*M7* - It’s an hour being put back, it is a lot of take, take, take at work sometimes and it is emotionally draining and physical and you’ve got life and death, [...] this CS can give you something for you as a person.

One of the measures of a policy document asks organisations to ensure the emotional well being of their staff (11) By offering CS organisations are demonstrating caring for the midwives as they care for the women.

**Support**

Midwives in the study felt the opportunity to engage in discussions about work were supportive to their practice. The conclusion of a UK study was “It is good to talk.” (24, 49) and was reflected in the experiences of midwives in this current study. The stack of various shape and colour objects in the model represents this concept of support.

*M6* - I like having the answers at the end. I like the completion of the session that says: this is what’s come up and these are some things I might be able to do about it, and coming away with either acknowledgement of the process or whatever happened or strategies. Like for me personally it has helped with dealing with conflict stuff, and people, or my own personal issues with other people without ever having to involve them because it was me
that was able to adjust things. The clinical supervisor gives you the keys... to unlock what is in your head.

Clarity

Midwives described getting clarity, examining feelings or perspectives in a situation; as important to move on from an unsettled place and a concept that also supported self care. It is represented in the model as a wise old person or wizard. (See Fig 4).

M10- ... I felt like it really was a way to support my practise, to clarify, my goals really, in my career and my practice, like it was able to kind of nut out, where I wanted to go with different situations, clinically or professional development, whereas before it was kind of all jumbled around, it was one other opportunity to be more clear about where I am going.

Valued/ Morale

For an organisation to have effectively engaged staff, the midwives need to feel valued. The diamond in the model represents morale and feeling valued. The comments that came together to create this category include; supporting others, professional involvement, validation, proud, empathy, and motivated. These are qualities that boost morale and motivate staff to become active in organisational activities. A policy directive includes an outcome measure: ‘staff retention rates are high’ and ‘the organisation ethos focuses on supporting the emotional wellbeing of staff’. (11) These midwives discussed how CS has made them feel valued and motivated.

M3- ...there is this kind of move towards people doing extra courses and taking further study and lecturing at the uni so there are a lot of things that have happened, I think really boosted morale and got people motivated so I think it [CS] is one of the things.

Confidence

Confidence is represented in the model as an alert dog. Participants reported increased courage, confidence and strength to engage in difficult conversations by having CS; they spoke how this added to their personal growth and self confidence which were qualities to enhance their work practices and relationships.

M2- ...the confidence to have those conversations because I have now clarified in a safe situation that yes what I was doing was the right thing to do, and so it [CS] has given me the confidence to then say to a colleague...

Communication/ Relationships

Whether it was working in a case load group or in a ward setting, these midwives felt the structure of safe reflection offered by CS supported them improve working relationships and considered communication. Participants shared how CS helped in dealing with personalities and egos, working through blocks to build connectedness. They described how by developing a relationship
with their supervisor and a culture of having regular CS assisted participants learn from each other and situations. The multi coloured ball depicts the multiplicity of factors involved in communication and relationships.

*M9* - *so just to be really open and be able to express that in a supported environment actually has made our relationship really harmonious. So I think it’s [CS] really good for that. It has made us deal with things as they come up.*

*M2* - *... I would have just been left in limbo with that situation and that person I think. So it enabled me to actually look at the situation and address it with that person*

**Best Practice**

Best practice includes not only clinical supervision supporting midwives to work to a high standard but also about changing behaviour to ensure standards. Concepts that midwives discussed that made up this benefit category included midwives examining their clinical practice, best practice, feeling safe, practice standards, change behaviour, and talking about CS as core business or a part of best practice itself. Midwives who had experienced regular sessions agreed CS was important to them to ensure standards and safety.

*M2* - *I think that is what I want to know in my life how I can be the best I can and I think CS gives you the opportunity to look at yourself [and your practice] and then start to bring the “highest me” (laughs)*

*M6* - *So that’s the benefit, sharing what you’ve learnt— or what you’ve gained from it[CS], because without even going, other people can still gain something from your experience.*

Participants acknowledge that there is not a direct path between CS and all the benefits described. The model has the double ended green arrows representing that sometimes it is an ongoing process or a multidirectional path.

*M9* - *Even if you didn’t get it immediately you come to a realisation yourself. That’s the thing, it is with you, that you have the answers, no one else has got them for you, but this gives you the forum to start to be able to find them, “the key to the door” (laughing.) I think that starts the process but sometimes the light or where ever you end up is actually (hesitantly) that process might begin it, but it keeps on unfolding for a time after. The work goes on in your head after a session.*

The experiences of these rural midwives and the benefits as they have explained are found in existing literature in other professions and locations, *(5, 6, 28, 29)* reported in the literature as; increased feelings of support and personal well being, increased knowledge and awareness and possible solutions, increased confidence, decreased emotional strain and burnout, higher staff morale, increased staff satisfaction, increased participation in reflective practice and increased self awareness. There was little literature from rural or Australian midwives about clinical supervision however the benefits described by the participants are consistent with other authors and resonate in the context of rural midwives.
Outcomes

Iteration three of the model showed to participants stopped at benefits (as seen in Appendix 7). By using the ‘play of life’ techniques as suggested by participants and viewing it from different perspectives it was noted the model was incomplete. It was needed to understand where the benefits led. By exploring the literature and the transcripts and pursuing theoretical sampling the circular nature of the process was discovered and validated by participants. They discussed the concept that though they felt the benefits of CS individually, there was a radiating effect through the team, to clients and management which meant the whole organisation benefited. By following the golden thread in the model an interpretation of the outcomes will be explained.

From the core category of safe reflection, the golden thread weaves through the benefits described in the model and discussed in the literature and encircles the midwife (see Figure 5), symbolising how all these factors are linked. They come together to produce a confident, supported midwife, depicted in a more confident pose than the questioning midwife behind the blocks at the beginning of the model.

Authors have linked these benefits for staff with positive outcomes for clients or organisations using various tools including a burnout inventory and job satisfaction survey, where it was noted that effectual CS for nurses in Finland has been linked with high scores in human centered nursing activities and nursing qualities that promote patient’s coping strategies.(29) The positive outcomes of these benefits for clients and organisations have also been noted in settings such as mental health(46) and in various countries(24, 29). As the benefits described by other authors are also described by these rural midwives it could be concluded the outcomes described by other authors could be transferable to this setting also. The midwives in this study described wanting to do a good job for their clients.

M7- I know I do good work when I’m feeling relaxed and good about myself.

M2- think having reflected on my practice it has definitely helped, and it’s made me talk to other colleagues about what they do and where they go with their practice, so we are all on the same page is really the important thing. [For patients]

Clinical Supervision for Role Development model has as its aim decreased anxiety results in increased spontaneity and creativity.(20) The aims are to be an engaged and motivated clinician who gives best care to clients.

The golden thread continues its path to incorporate the team. Individual midwives who participate in CS are always part of a larger group

Figure 5 Outcomes of safe reflection.
whether that is a small caseload group or part of a bigger hospital based multidisciplinary team, if the individual is feeling supported the group benefits.

M10- ...we can get an issue and we have a neutral space with [supervisors name] and we can say as much or as little as we want about the ... issue, and I’ve noticed that people say clinical supervision brings up stuff from team members that they wouldn’t necessarily say one on one, but gives a safety structure in a way to be able to say, like the CS has allowed um... more transparency, more honesty to propel the group to work more cohesively together.

The cohesive team gives quality care to their clients depicted in the model as a couple with a baby, also encircled with the golden thread.

M4- it validates what I’m doing and why I’m doing it. It’s around safety; it’s around, best practice guidelines. It’s about doing a good job for the women. You have supervision and you reflect on what you’re doing and why you’re doing it, it leads to better practice in every instance.

The thread continues past the client, having a supportive manager was enabling to midwives to access CS but equally clinical supervision was seen to support managers’ in their role also.

M10 -... [Name] saw it would help.... in managing. Like now [...] goes to us ‘oh you can discuss that with [name] in clinical supervision.’

The golden thread returns from the well-supported, confident midwife to the supportive manager via the team and the clients to symbolise the whole organisation is benefiting from this place of safe reflection for the staff. Midwives in this study described how they gave feedback to their managers of the benefits of CS and midwifery managers in this study agreed CS helped them in their management role to further support their staff. It was noted by one author that where the introduction of CS was an integral professional nursing activity, especially in settings where there was apparent backing from managers, it was not seen as a resource challenge, rather the organisation benefitted from role modelling positive management practices(46).

M11- Clinical supervision will sort that, [...] hand it back and say well you need to take that and sort that. That is actually an issue that is perfect for clinical supervision because that is a team decision, you actually don’t need [management] involvement in that. Yeah so that’s um a pretty good example of how it’s helping [manage] in a good way (chuckles).

The quote of an experienced long term midwife highlights the importance midwives place on clinical supervision.

M4 - But when midwifery isn’t going well it goes unwell dramatically, and very rapidly, and they’re the times I think that we in particular need to have access to supervision to be able to talk about the impact... not so much about the clinical ‘I did this, I did that’, that’s what RCA’s [ root cause analysis] are about, but [...]it’s vital to have the opportunity to understand the impact, the emotional impact that sort of situation has had on you and be able to explore that, and to look at your reaction to it and, it’s not only just what’s happened in.. particularly in the ward at that
time, there’s other factors that come in, you know, that come in from your personal life, be grief
and loss and whatever, that also impact on you, so that can make a difference to how you
respond to what’s going on at work. I don’t think it’s possible to separate out what may be going
on in your personal life, probably work life, but what happens in your work life, your sense of how
you make of it, or your understanding of what’s been going on, can be impacted on if you’re not
emotionally taken-care-of across the board.

The dynamic interrelatedness of factors that built over time, discussed by midwives and
demonstrated in the model led to achieving outcomes of greater clinician engagement and support
and positive team communication, also support organisational goals and lead to better client
outcomes (10, 11) A NSW survey identified opportunities in the NNSW LHD for improvement in how
we communicate and how we treat each other, (50)those participating in CS describe enhanced
team work and communication which are consistent with achieving these aims.

Study Strengths

The researcher was known to all interviewees - this insider perspective encouraged open
and honest communication.

Having an experienced researcher as mentor who was readily available and an outsider, who
was able to provide practical assistance such as double coding and available for critical conversations
increased rigor.

Study Limitations

The interviews were conducted with only midwives who had participated in CS. Further
interviews with nonparticipants or those wanting to participate and not having access to CS could
give further insights. Midwives in this category were not included in the study design as it was about
the impact for those participating. Non participants may have been able to provide more insights as
the model progressed.

Conclusions

The aim of this study was to understand the impact CS has had for a group of rural midwives.
The training provided to rural midwives by NaMO in 2008-2011 in Clinical Supervision for Role
Development has not been evaluated, this study gives insight into the impact that strategy has had
for a small group of regional midwives. These outcomes are likely to support the original purpose of
providing CS training for rural midwives in supporting the rural workforce and aiding retention in an
aging workforce if CS can actually be implemented and the disablers can be overcome.

Clinical supervision for midwives in rural NSW was largely unheard of when training for the
100 rural midwives was commenced in 2008. The implementation of CS for midwives in NNSW LHD
following this training also noted that this group had limited exposure to the concept of clinical
supervision as a work place activity and this provided a significant barrier to embracing the support
CS offers. However having had an experience of it, midwives themselves became enablers of others
to access CS, and when offered the opportunity found it beneficial to their practice and well being.

Against this background the Grounded Theory model generated by this study has at its core
clinical supervision as an opportunity for safe reflection, and demonstrates the multifactorial
interrelationships between clinical supervision, management, midwife, team, clients and organisation.

Findings from this study of the benefits such as; self-care, support, clarity, feeling valued, increased confidence, communication and best practice were consistent with stated benefits and outcomes from other settings and demonstrate that they can be applied to the group of midwives in rural NSW.

The additional finding of lack of knowledge and misconceptions about CS among rural midwives informs the recommendation for demystifying workshops and in-services.

The benefit to managers of implementing clinical supervision for midwives to support them in their management roles is novel to this research and has not been focused on in other research; this finding gives credibility to those managers wanting to pursue CS as a staff support strategy and may resonate with other midwives in Australia and can add to the body of knowledge regarding reflective models of clinical supervision for midwives in Australia.

**Recommendations**

Rural NSW midwives in this study confirmed that their experiences of Clinical Supervision are consistent with literature about CS in other disciplines. Additional findings show a lack of knowledge and misconceptions of midwives about CS and inform the recommendation to increase awareness of this support strategy. The implication for midwifery managers in having this support mechanism available is that it can augment their management role.

The following recommendations for managers are based on these findings and conclusions.

- Clinical supervision be recognised as an integral part of midwifery practice and time for CS is made available to all midwives requiring this support.
- Demystifying workshops and in-services are offered regularly to increase knowledge of clinical supervision as an important workplace support.
- A comprehensive and flexible Clinical Supervision Practice Guideline be developed to fulfil the requirements of making CS available to all staff caring for families (PD 2010_17).
- The model developed in this study be recognised as a guide for implementing reflective clinical supervision for midwives by including it in the practice guideline.
- Midwifery managers across rural NSW utilize their resource of 100 trained clinical supervisors by supporting them with time and their commitment to implement this reflective practice. This would leverage the funds already spent on training.
- More staff are trained in the skills of clinical supervision to ensure adequate numbers of clinical supervisors are available.
- Reflective clinical supervision should be implemented for other areas of nursing in N NSW LHD to assist fulfil the organisational aims of improving how we communicate and how we treat each other.
- The potential for interdisciplinary CS be investigated to aid access in rural areas.
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Appendix 1 – Welcome letter for clinical supervisor trainees from the chief nursing and midwifery officer.

Welcome to Clinical Supervision.
In 2007, two Midwifery Workforce Forums identified the need for a Clinical Supervision Framework for midwives and midwifery students across NSW as a strategy for workforce planning and development.
The Nursing and Midwifery Office (NaMO) is committed to facilitating the implementation of Clinical Supervision for Midwives across NSW.

Adjunct Professor Debra Thoms
Chief Nursing and Midwifery Officer
Nursing and Midwifery Office
NSW Health
Appendix 2 - Survey

Survey about Clinical Supervision in Midwifery

Dear Colleague,

I am commencing a process of evaluating clinical supervision for midwives in the NNSW LHD. This survey seeks to understand your knowledge & involvement with clinical supervision. Some questions about job satisfaction and demographics are also included to explore whether they relate to clinical supervision. Enjoy the chocolate as a sign of my appreciation as you work through the survey! Please be assured that your response is anonymous and will be treated with complete confidentiality. No one response to the survey will be focused on - only collective analyses will be conducted. To safeguard your confidentiality, there is a sealable return envelope included in the survey kit, to allow for completed surveys to be returned directly to Greg Fairbrother, (Research Fellow, Southern Cross University), where they will be entered into a research database. I will not personally view any completed surveys. The survey should take approx 10 minutes to complete. 😊 There is also an opportunity to participate in one to one interview.

Many thanks, Bev Love (CMS, The Tweed Hospital)

1. In your own words, what is clinical supervision?

2. Are you aware clinical supervision is available in this LHD?
   Yes ☐ No ☐ not sure ☐

   If yes, where have you heard about clinical supervision?

3. Have you accessed clinical supervision?
   Yes ☐ No ☐ not sure ☐

   a) If yes, how many sessions have you had?
      1. ☐ 2. ☐ 3. ☐ More. ☐

   b) What kind of sessions were they?
      Group ☐ Individual ☐ Both group & individual ☐

   c) If no, would you like to access it?
      Yes ☐ No ☐ not sure ☐

   d) If you’ve not accessed clinical supervision but would like to, what have been the barriers to accessing it?

4. If you have been involved, please indicate how strongly you agree or disagree with the following statements about its usefulness:

(Please turn to back)
a) It helps with my clinical work:

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<td>Fully agree</td>
<td>Agree</td>
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Please give a reason for your rating: ..........................................................................................................................
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b) It helps with my non-clinical work

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Please give a reason for your rating: ..........................................................................................................................
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c) It helps me personally

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Please give a reason for your rating: ..........................................................................................................................
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d) It has changed the way I respond to situations

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Please give a reason for your rating: ..........................................................................................................................
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e) It has helped me with my career goals

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Please give a reason for your rating: ..........................................................................................................................
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6. Please make any further comments that come to mind about clinical supervision:
..............................................................................................................................................................................
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.
7. The following demographic questions are here not to identify you, but to help with gauging the cross-section of midwives who have responded to the survey:

a) What is your age range?
- □ <30
- □ 31-40
- □ 41-50
- □ >50

b) Your gender?
- □ F
- □ M

c) What is your highest educational attainment in midwifery or other health related discipline?
- □ Masters or above
- □ Postgraduate Certificate/Diploma
- □ Bachelor Degree
- □ Undergraduate Diploma/Nursing/Midwifery Certificate

d) What area/s do you mainly practice in?
- □ Antenatal
- □ Postnatal
- □ Birth suite
- □ Caseload
- □ Community
- □ All areas
- □ Management
- □ Other...........................................................

e) About how many years have you worked in midwifery overall? ................. yrs

f) Where is your work based?
- □ Large Hospital (> 150 beds)
- □ Medium Hospital (40- 149)
- □ Small Hospital
- □ Community
- □ Across district

(Please turn to back .......)
Please complete the attached job satisfaction index. This is included to gain a sense as to where NNSW LHD midwives as a group are in relation to job satisfaction.

Below are a series of statements concerning your thoughts/feelings about your job. Please circle the number that most appeals:
1 = fully agree; 2 = agree; 3 = neutral; 4 = disagree; 5 = definitely disagree.

There are a couple of general open-ended questions at the end of the survey. Please say exactly what you think/feel. Please be assured that your anonymity is guaranteed and responses will be viewed and analysed collectively, not individually.

### How much you enjoy your job

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<td>My work gives me a lot of satisfaction</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My work is very meaningful for me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I am enthusiastic about my present work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>My work gives me an opportunity to show what I’m worth</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>In the last year, my work has grown more interesting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>It is worthwhile to make an effort in my work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Doing your job

<table>
<thead>
<tr>
<th>Statement</th>
<th>fully agree</th>
<th>agree</th>
<th>neutral</th>
<th>disagree</th>
<th>definitely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have enough time to deliver good care to clients</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have enough opportunity to discuss client issues with colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I have enough support from colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I would function better if it was less busy on the unit</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel able to learn on the job</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel isolated from my colleagues at work</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel confident as a clinician</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I like the way my unit is run</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### The people you work with

<table>
<thead>
<tr>
<th>Statement</th>
<th>fully agree</th>
<th>agree</th>
<th>neutral</th>
<th>disagree</th>
<th>definitely disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>It’s possible for me to make good friends among my colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I like my colleagues</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel that I belong to a team</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>I feel that my colleagues like me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Overall

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>What’s the best thing about your work?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>What’s the worst thing about it?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To ensure confidentiality please separate this page and place it in Interview Participation box in tea room or return it via internal mail to Bev Love CMS, Women’s Care Unit, The Tweed Hospital if you have an interest in being interviewed as part of this research.

I also hope to do some interviews to enhance understanding of the impact of clinical supervision for midwives. The focus of the discussion would be about your feelings about clinical supervision and your midwifery practice. Would you be prepared to be contacted to arrange a one on one recorded interview at a time and location of your choosing?

Name: ........................................................................................................................................

Contact number................................................................................................................................

Interested in more information about Clinical Supervision or this research?
Contact Bev Love;

Mobile: 0402 158 030
Email: BevHLove@gmail.com

Or I can contact you...

Name........................................................................................................................................

Contact Number................................................................................................................................

Thank you for taking the time to complete this survey.
Please return the survey in addressed envelope provided via internal mail by 28th Feb to:
Dr Greg Fairbrother (Research Fellow, Southern Cross University).
3rd Floor, Crawford House
Lismore Base Hospital
Appendix 3 - Selected Survey Results
Selected Results Report: Survey of NNSW LHD midwives about clinical supervision.

Background
An aim of the work on Clinical Supervision (CS) in the NNSW Local Health District (LHD) study was to determine the impact of Clinical Supervision (CS) for midwives. Were the benefits described in the literature for other disciplines and for midwives in other countries, also apparent in the midwifery context in the LHD? In consultation with an experienced researcher / mentor, a quantitative survey was designed and distributed. Its aim was to assist in getting an overview of midwives’ knowledge, uptake and general impression and understanding of CS. A job satisfaction inventory was included. It is anticipated further analysis of this survey will be attended in the future.

The decision to design our own survey tool was reached following literature searching. The search revealed that The Manchester Clinical Supervision Scale (1) had been validated in the UK, though not among midwives. Further, its content was focused for primary use in the mental health arena. CS has been linked to burnout and job satisfaction (2). The Maslach’s Burnout Inventory was perused but found to be solely burnout-focused(3) Whilst burnout was considered of peripheral relevance to this CS work, it wasn’t considered to be a major factor at play among NNSW midwives. (4). Level of job satisfaction was on the other hand considered to be of considerable relevance as a factor likely to impact on response to and awareness of CS. A 14-item job satisfaction tool validated in Australia for nurses was considered the most relevant tool to investigate and interpret this, and was included in the CS survey (5).

It was hoped that information gained from the quantitative survey would inform any appraisal of the results arising from the major study in the mixed method inquiry – the qualitative grounded theory study among CS participants.

At the time of survey, many parts of the LHD had not been exposed to CS. It was identified that a quantitative survey could usefully be conducted at this time, as a baseline setting exercise. Of particular interest was baseline knowledge about CS.

Method
There were 225 midwives working in six maternity units or birthing services in hospitals in the NNSW LHD at the time of survey distribution. The distribution of the survey was achieved via placing a survey into each individual’s mail tray, or equivalent depending on local communication systems, by the researcher or a nominated supportive colleague at each site, over the last week in January and the first week of Feb 2013 with a closing date of the 28th of February. Participation was encouraged by including a Freddo chocolate with each survey as thanks for their time. These were well received with one participant saying they felt too guilty to eat the chocolate until they had completed the survey! A sealable return envelope was included with all surveys to facilitate anonymous return. The surveys were returned via internal mail to the researcher’s mentor who had a research assistant enter the information into a spreadsheet for ultimate analysis in SPSS. All survey responses were unseen by the researcher. A total of 118 surveys (52% response) were returned.
Selected Results

Figures 1-3 display thematically analysed responses to open ended questions seeking information about respondents understanding of CS, how they have been exposed to it and the barriers to uptake. Note that response numbers may not add to 118 (the total sample size) as respondents may have canvassed more than one concept in their response, or may not have responded at all.

**Fig 1: What is clinical supervision?**

- A skill acquisition exercise: 18 responses
- A critical incident debrief: 21 responses
- Someone assessing clinical procedures: 14 responses
- Don’t know: 5 responses
- Patient education: 3 responses
- Advice giving: 2 responses
- Support to discuss the emotional impact of work issues: 72 responses
- Facilitated reflection with a trained person: 68 responses
- Professional and personal growth and development: 51 responses
- Time in a confidential, formal, safe, structured process: 50 responses

[Bar chart showing the distribution of responses with CS Aware in green and CS Unaware in red]
Respondents who had had involvement with CS were asked to rate its effect (on a 1-5 Likert scale see appendix 2) on their clinical work, their non-clinical work, themselves personally, their situational responses and their career goals. Respondents were also asked to indicate the number of sessions they had
participated in. The relationship between session frequency with self-reported effects indicated that greater session frequency was strongly related to greater effect in the clinical, non-clinical, personal and situational response domains (ANOVA: P<0.05), but not the career goals domain.

References

Appendix 4 - Participant Information

Participant Information sheet

You are invited to participate in a research study about Clinical Supervision for midwives in Northern NSW LHD. Your information is valuable in helping us understand your perspective on effects of clinical supervision and enabling and disabling factors in the uptake and implementation of clinical supervision for midwives. The study is being undertaken by Bev Love a Clinical Midwifery Specialist at TTH and Clinical Supervisor for midwives in NNSWLHD and Dr Greg Fairbrother from the School of Health and Human Sciences, Southern Cross University.

If you agree to being involved in the research, we would like to conduct one tape recorded interview with you at a time and location of your choosing in the next month, then another tape recorded interview with you, about six months later, if you remain available then. The focus of the discussion would be your midwifery practice, your experience of clinical supervision, and whether, how and where it may have been of use to you in your practice and your professional life.

Any information collected is confidential. If you choose not to participate in the research, this will have no effect on any future access to clinical supervision.

If you decide to participate, please complete the Informed Consent Form below. You are free to withdraw your consent and to discontinue participation at any time.

Inquiries
If you have any questions, please feel free to speak with Bev Love on 0402 158 030. You will be given a copy of this form to keep. The North Coast NSW Human Research Ethics Committee has approved this research. If you at any stage have a complaint about the research project you may contact the North Coast NSW Human Research Ethics Committee, Research Ethics Officer, PO BOX 821 MURWILLUMBAH NSW 2484 PHONE: 0266720269 or email EthicsNCAHS@ncahs.health.nsw.gov.au.
Informed Consent

I .........................................................................................................................................................................................(name) have read the information contained in the information sheet. I have also received a verbal explanation of the study by the researcher, and agree to participate in this study.

I understand that:
Any information that is obtained in connection with this study is confidential.
I am free to withdraw my consent and to discontinue participation at any time without any problems.
I can contact Bev Love on 0402 158 030 at any time if I have any questions to ask or comments to make.
I may be involved in tape recorded interviews which will be about my participation in Clinical Supervision and complete a survey form.
I understand that agreeing to participate in this study will not affect future access to clinical supervision or impact on my relationship with the Northern NSW LHD.
I will receive a summary report on the results of the study if I request it.
I can lodge a complaint about the research project by contacting North Coast NSW Human Research Ethics Committee, Research Ethics Officer, PO BOX 821 MURWILLUMBAH NSW 2484 PHONE: 0266720269 or email EthicsNCAHS@ncahs.health.nsw.gov.au. I have read the information above and agree to participate in the study.

Name:

Signature:

Date: ...
Appendix 5 - Possible Interview Questions
Adapted from:
Clinical Supervision Interviews 2009-2010. Details, themes and experience of Clinical Supervision; health professional perspectives. Justice Health: 2010. Author: Sue Szabo

The focus of the discussion would be your midwifery practice, your experience of clinical supervision, and whether, how and where it may have been of use to you in your practice and your professional life.

In your own words, what is clinical supervision?
Can you tell me where you have come across clinical supervision?
Can you tell me how you came to the decision to take part/ not participate in clinical supervision?
Do you have any expectations of clinical supervision?
How did your first few sessions go?
Is there a particular theme of your sessions?
Have you found it helpful in any way?
Can you talk about any unhelpful aspects of the experience?
Has clinical supervision made a difference to you at work?
If it has, can you tell me about this?
Have you noticed any changes in your practice or your workplace since you have had clinical supervision?
What is your opinion of clinical supervision?
What is your preferred type of clinical supervision- individual or group supervision? Why?
What do you think about the idea of mandatory clinical supervision?
How important is privacy, confidentiality and trust in clinical supervision?

Also included after interview one, midwives were asked to recall if there was a specific session they had that influenced their practice and were prepared to share.
The opening question generated discussion and the interview took a conversational flow with the researcher looking over the questions at the end to decide if all topics were adequately covered.
Appendix 6 - Coding and example from code book

The process was fluid and physical, taking each line of the transcript and open coding with the researcher and mentor who were blinded to each other was done on the first round of interviews and then discussed.

Key codes identified, and grouped into categories. These categories were sorted into higher levels of abstraction.....

Such as Time...
<table>
<thead>
<tr>
<th>Time</th>
<th>Description Definition</th>
<th>When to use (qualification)</th>
<th>When not to use (exclusions)</th>
<th>Examples from transcripts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anything to do with time</td>
<td>Time in Sessions</td>
<td>Time in Sessions</td>
<td>1-94 until I did it the first couple of times then I realised probably the value of it... Actually brings out.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>just a time out to reflect</td>
<td>Time to get away from clinical work, clinical work takes priority over reflective time</td>
<td>2-218 once we’d had a few sessions and there was an incident or something that happened even personally I felt it was a safe forum,</td>
</tr>
<tr>
<td></td>
<td>positive-Valued over time</td>
<td>Time to work on self</td>
<td>Time to work on self</td>
<td>2-309 I think what cs has done for me over time given me the confidence that my practice is good and that yes I am prepared to look at some things... I am prepared to look at my practice and change the things that need to be changed and the courage to...a lot of it is about confronting those that have perhaps got a different view or different way or appear too (brilliant???) or to address it .</td>
</tr>
<tr>
<td></td>
<td>negative-Difficulty getting time</td>
<td>Process over time took a couple of sessions to get value</td>
<td>Process over time took a couple of sessions to get value</td>
<td>5-34, until we found out how good it was (laughs) and then we kind of, enjoyed making time for it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paid time to reflect</td>
<td>Paid time to reflect</td>
<td>3-73 if I had a desperate need I would seek it out and it wouldn’t matter what time. I think if you were sort of really struggling with something and you really wanted to deal with things then I’d be happy to do a session after work it wouldn’t bother me.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enjoyed making time for it</td>
<td>Enjoyed making time for it</td>
<td>4-273 The unhelpful thing is trying to get people off a roster an how to manage it. You know, ’cause the most opportune time is between a morning and an evening shift when that crossover a shift, but even then it’s still hard to get people off a line to actually attend to something like supervision. I don’t think our organization places enough value on it yet to actually make that happen.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Develop over time</td>
<td>Develop over time</td>
<td>5-140 we met for two hours once a month and it sometimes didn’t feel like enough.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ongoing process</td>
<td>Ongoing process</td>
<td>2-270 I think it is an excellent service... That you can talk to someone safely for an hour and get paid for it... Laughter what more could you want?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sessions sometimes not long enough time</td>
<td>Sessions sometimes not long enough time</td>
<td>6-211 ...suppose it’s always just in the back of your mind about when you get to go there, [CS] and taking time away from the ward</td>
</tr>
</tbody>
</table>
Appendix 7 - Iteration 1, 2 & 3

Iteration 1

Iteration 2

Iteration 3