Effective use of technology in clinical supervision

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ABSTRACT

Clinical supervision is integral to continuing professional development of health professionals. With advances in technology, clinical supervision too can be undertaken using mediums such as videoconference, email and teleconference. This mode of clinical supervision is termed as telesupervision. While telesupervision could be useful in any context, its value is amplified for health professionals working in rural and remote areas where access to supervisors within the local work environment is often diminished. While telesupervision offers innovative means to undertake clinical supervision, there remain gaps in the literature in terms of its parameters of use in clinical practice. This article outlines ten evidence-informed, practical tips stemming from a review of the literature that will enable health care stakeholders to use technology effectively and efficiently while undertaking clinical supervision. By highlighting the "how to" aspect, telesupervision can be delivered in the right way, to the right health professional, at the right time.

Introduction

Continuing professional development requires robust support mechanisms to maximise opportunities for achieving best practice in clinical settings (Parkinson et al., 2010). Clinical or professional supervision is one mechanism to do this (Moran et al., 2014). Clinical supervision has been shown to benefit the patient, the health professional and the organisation (Bambling et al., 2006; Farnan et al., 2012; Fitzpatrick et al., 2012). While the benefits of supervision is widely accepted, the terminology about and the definition of clinical supervision is marred by confusion (Dawson et al., 2012; Martin et al., 2014; Ducat and Kumar, 2015). In this article, clinical supervision is defined as a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence (Edwards et al., 2005; Simpson and Sparkes, 2008).

The need for clinical supervision in non-metropolitan settings where health professionals face a number of challenges in accessing professional support is well-documented (Ducat and Kumar, 2015; Edwards et al., 2005; Simpson and Sparkes, 2008; Martin and Kumar, 2013). While supervision has historically been provided face-to-face, the use of distance supervision using technology is on the rise (Brandoff and Lombardi, 2012). Distance supervision or telesupervision refers to clinical supervision conducted by using technology such as telephone, email or videoconferencing (Brandoff and Lombardi, 2012). Videoconferencing is the use of video in real time to connect and this includes use of platforms such as Skype. This usually occurs when the supervisor and supervisee are not co-located. With the rise of social media, tools such as blog, micro-blog, wiki, video chat, virtual world, podcast and social networks can also play a role in telesupervision (Kind et al., 2014). Moving from traditional face-to-face supervision to telesupervision calls for clear guidelines and recommendations for using technology to undertake clinical supervision. It is important to recognise that telesupervision is not the same as tele/distance education (which also uses technology). While tele/distance education has a particular focus on teaching and learning and as such been researched extensively (Chi and Demiris, 2015; Bain et al., 2015), the use of technology to support health professionals is the focus of telesupervision.

To date, there is only limited information in the literature on the quality and effectiveness of telesupervision (Ducat and Kumar, 2015; Manosevitz, 2006; Wood et al., 2005; Robson and Whelan, 2007). Manosevitz (2006) noted that supervision using technology, such as telephone, while frequently used is rarely evaluated. He argued that there was a dearth of information on how supervision using technology is best undertaken and highlighted the need to address persistent knowledge gaps. More recently, Ducat and Kumar (2015) completed a systematic review of professional supervision experiences of allied health practitioners working in non-metropolitan health care settings. They echoed Manosevitz's (2006) observations and noted that the concept of, and the impact from, telesupervision requires more attention. Telesupervision has the potential to achieve the same benefits as face-

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to-face supervision and offers a very promising approach to supervision, particularly for geographically isolated practitioners (Miller et al., 2010; McColgan and Rice, 2012; Rousmaniere et al., 2014). This article, based on a review of the literature, outlines ten evidence-informed, practical tips that will enable health care stakeholders to use technology effectively and efficiently while undertaking clinical supervision. This can assist health care stakeholders to become better informed and confident while engaging in telesupervision.

1. Set clear expectations and goals for telesupervision

Clinical supervision has been shown to have consistent positive outcomes when the purpose and goals of supervision are explicitly stated and roles of the supervisor and supervisee are clarified at the outset (Martin et al., 2014; Kenny and Allenby, 2013). This is true for all types of clinical supervision, regardless of the mode or medium used and therefore is a critical first step. Supervision goals are set at the start of the supervision partnership. During this stage, a supervision agreement is developed between the supervisor and the supervisee (Martin et al., 2014). This may take one or more sessions and is dependent on various factors such as the experience level of the supervisor and supervisee, supervision needs of the supervisee, organisational policies around professional support activities etc.

Where possible, it is recommended that the initial sessions where goals and expectations are discussed and supervision contract developed, be undertaken face-to-face before transitioning into telesupervision. If initial face-to-face supervision sessions are not feasible, telesupervision using videoconference is recommended (as opposed to using a telephone). This is because the ability to read non-verbal cues is preserved while using videoconference. Furthermore, cohesion between participants has been shown to improve when non-verbal cues are able to be seen (Hambley et al., 2007).

2. There is no one size fits all with the medium and mode of telesupervision

Wood et al. (2005) recommend that a range of telecommunication options be incorporated into the supervisory process to maximise the benefits of telesupervision. Different health professionals engage with telesupervision differently, have different learning styles and this flexibility recognises there is no one size fits all. It is essential that the medium of technology used in telesupervision is carefully considered. This will largely be dictated by the clinical supervision needs of the supervisee. For example, a supervisee with a learning need related to a hands-on skill or clinical task, such as bandaging a limb, would find videoconference more beneficial than teleconference. To a lesser extent factors such as equipment, network capacity and technical support available may also influence the choice of medium used. Optimal and effective use of technology has been shown to lead to positive supervision outcomes (Ducat et al., 2015). Hence it is imperative that the supervisee and supervisor are proficient and competent in the technologies being used (Rousmaniere et al., 2014). Some supervisees or supervisors may benefit from targeted initial training in the use of equipment related to the medium chosen (e.g., videoconference). Such training should aim to educate participants about the mechanics and the use of the equipment and provide an opportunity for hands-on practice operating the equipment as means of familiarisation (Wood et al., 2005; Cameron et al., 2015).

Furthermore, it is recommended that face-to-face meetings should complement telesupervision in an ad hoc or opportunistic manner. This recommendation is generally supported in the telesupervision literature (Manosevitz, 2006; Wood et al., 2005; Martin et al., 2015; Reese et al., 2009; Sorlie et al., 1999). Some studies found that augmenting telesupervision with face-to-face supervision resulted in the supervisee rating their supervision as more effective (Martin et al., 2015; Reese et al., 2009). Furthermore, Martin et al. (2015) found that

the reverse was also true in that some supervisees that had no prior face-to-face contact with their supervisors reported concerns about their telesupervision partnership.

3. Embed telesupervision into a sound framework based on educational principles

Professional support activities achieve best outcomes when they are underpinned by established frameworks and educational principles (Schichtel, 2009; Nancarrow et al., 2014). Doing so will ensure that clinical supervision theory and practice are linked. As health professionals are confused about the pragmatics of the clinical supervision process (Dawson et al., 2012; Martin et al., 2014), it is essential for the supervisee and supervisor to clarify what clinical supervision means and how it will be undertaken. The Proctor's model of clinical supervision is informed by rigorous research and commonly used in practice (Martin et al., 2014; Winstanley and White, 2003). As per this model, clinical supervision is divided into formative, normative and restorative domains (Winstanley and White, 2003). These domains can be used to structure supervision sessions. More recently, Nancarrow et al. (2014) proposed a supervision and support framework, developed by thematic analysis of existing supervision frameworks, called 'connecting practice'. This is a practitioner-centred framework that recognises the tacit and explicit knowledge that the supervisor and supervisee bring to the supervision partnership (Nancarrow et al., 2014). Embedding telesupervision onto a framework, which is paired with educational principles, is likely to maximise supervision outcomes (Sorlie et al., 1999).

4. Focus on the supervisory relationship

Supervisor-supervisee fit, which results in a positive supervisory relationship, has been shown to be a critical factor for effective and high quality supervision (Martin et al., 2014, 2015; Ducat et al., 2015; Wetchler et al., 2007), especially in telesupervision. A positive supervisory relationship is achieved by mutual trust and respect for each other (Sorlie et al., 1999). Some reports of telesupervision in the literature note that participants felt telesupervision was on par with face-to-face supervision when the supervisor and supervisee had a positive supervisory relationship and had met face-to-face previous to entering the telesupervision arrangement (Manosevitz, 2006; Cameron et al., 2015; Sorlie et al., 1999; Mason and Hayes, 2007). Therefore it is recommended that the supervisee is matched with the right supervisor for an optimal supervisor-supervisee fit and where possible is provided with a choice of supervisor (Martin et al., 2015, 2016).

5. Formulate a plan to manage technical problems

Technology is not without its limitations with poor reliability and connectivity being the commonly reported technological problems. It is therefore essential to anticipate and manage technical problems proactively (Chou et al., 2012) in telesupervision. Benefits of supervision undertaken via technology is maximised when there is an action plan for managing technological glitches. Chou et al. (2012) argue that a plan outlining anticipatory solutions to common technical issues need to be in place before a telesupervision session. Proposed strategies include having a back-up plan for contacting other participants involved in the teleconference (e.g., via email or another phone number), and identifying a technical support point person to help with resolving issues (Chou et al., 2012). It is recommended that a plan to manage technical problems be developed and included in the clinical supervision contract. This plan is likely to vary depending on the medium of technology used, with dedicated teleconferencing systems more likely to require technical support than mobile technologies. It is recommended that aspects such as other means of contact, back-up phone numbers and training in the use of equipment be considered.