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"Unscrambling what's in your head": A mixed method evaluation of clinical supervision for midwives

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ABSTRACT

Background: As a strategy to promote workforce sustainability a number of midwives working in one health district in New South Wales, Australia were trained to offer a reflective model of clinical supervision. The expectation was that these midwives would then be equipped to facilitate clinical supervision for their colleagues with the organisational aim of supporting professional development and promoting emotional well-being.
Aim: To identify understanding, uptake, perceptions of impact, and the experiences of midwives accessing clinical supervision.
Method: Mixed Methods. In phase one 225 midwives were invited to complete a self-administered survey. Descriptive and inferential statistics were used to analyse the data. In phase two 12 midwives were interviewed. Thematic analysis was used to deepen understanding of midwives' experiences of receiving clinical supervision.
Results: Sixty percent of midwives responding in phase one had some experience of clinical supervision. Findings from both phases were complementary with midwives reporting a positive impact on their work, interpersonal skills, situational responses and career goals. Midwives described clinical supervision as a formal, structured and confidential space for 'safe reflection' that was valued as an opportunity for self-care. Barriers included misconceptions, perceived work related pressures and a sense that taking time out was unjustifiable.
Conclusion: Education, awareness raising and further research into reflective clinical supervision, to support emotional well-being and professional midwifery practice is needed. In addition, health organisations need to design, implement and evaluate strategies that support the embedding of clinical supervision within midwives' clinical practice.

Statement of significance

Issue

Midwives aim to provide high quality maternity care however exposure to emotional stress has been identified as impacting on midwives' health and well-being, and contributing to burnout and attrition.

What is already known

Midwives are subject to high levels of emotional stress irrespective of their level of experience. Supportive strategies are needed to sustain and develop the midwifery workforce.

What this paper adds

Evidence that clinical supervision, as a reflective model, is a useful emerging strategy to support, develop and sustain midwives in their professional practice.

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Clinical supervision can positively support the emotional work, health and wellbeing, and professional development of midwives in a range of settings, irrespective of their level of experience. Workforce support and sustainability remain issues of high importance, particularly in a climate of changing models of midwifery care.

1. Introduction

Internationally there is growing awareness of the benefits midwifery care offers women and babies.[1–4] In order to achieve those benefits, provision of a well-educated and resourced maternity workforce should be identified as a key priority in workforce planning.[2–5] Midwifery, as a career provides the opportunity for rewarding and satisfying work, yet in resource rich countries such as Australia, this is not the experience of many midwives. An increasing body of evidence supports the notion that stress and burnout are common in midwives.[6–9] High levels of emotional distress also exist in the midwifery student population,[10] and newly qualified midwives experiencing distress report a loss of confidence when they feel unsupported in the workplace.[6,7] In addition, the average age of an Australian midwife in 2014 was 48 years with over half those employed being aged 50 years and over.[11] This situation has serious implications for the ongoing sustainability of the midwifery workforce. In order to plan appropriately for future workforce needs, the profession needs to identify and implement support strategies that promote the emotional wellbeing of midwives.[7,12]

One intervention receiving increasing attention as a possible strategy to better support midwives as well as nurses, and subsequently improve recruitment and retention, is clinical supervision (CS).[13,14] Challenges exist in defining CS due to a level of variation in meaning across the diverse professional health care groups. Historically the term, and the initial provision of support through CS, originated from the fields of psychoanalysis and social welfare,[15] and has been prominent in the literature in other disciplines such as psychology, social work, counseling and mental health nursing.[16–19] The central purpose of CS is the formal opportunity for guided reflection about professional practice, distinguishing it from direct supervision of clinical work, hierarchical oversight,[16,20] or other supports such as mentoring or preceptorship.[21,55] Clinical supervision is also quite different from the familiar statutory midwifery supervision as implemented in the United Kingdom.[22]

One well-recognised and long standing definition is that articulated by Bond and Holland,[23]

> *Clinical supervision is regular, protected time for facilitated in-depth reflection on clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development.*(p15)

More recently the Australian Clinical Supervision Association (ACSA) released the following intentionally broad definition;

> *Clinical supervision is a formal professional relationship between two or more people in designated roles, which facilitates reflective practice, explores ethical issues and develops skills.*[24]

In addition, both Bond and Holland[23] and ACSA[24] argue that the definition includes the necessity of facilitation by a supervisor with expertise in CS, with sessions focused on the needs of the supervisee. CS should also be available to healthcare workers throughout their career, and not limited to those providing direct care.[23]

The development of the 'supervisory alliance' through a strengths-based approach facilitates a partnership between the supervisor and supervisee/s, with similarities to the philosophy and approach underpinning midwifery models of care. It is important to determine and maintain the boundaries of the supervision relationship, particularly in relation to confidentiality in order for trust to develop. The role of the facilitator or 'supervisor' in CS is to guide the supervisee/s during an individual or group CS session, providing both support and gentle challenge as the supervisee's 'question' is explored. Although questions related directly to clinical procedures and competency usually sit with other forms of support e.g. clinical facilitation, the supervisee may be guided to reflect on their feelings or actions in relation to interactions and events in the clinical arena (positive and negative), and consider subsequent steps. Benefits of CS reported in the literature include: feeling more supported within the work environment; increased levels of knowledge, confidence, and competence in the workplace; reduced levels of stress, anxiety and burnout; and improved retention of healthcare workers.[14,16]

Perhaps not surprisingly there are also a number of different approaches to CS including developmental models, which have evolved from within the various health disciplines. Michael Consedine[25] a New Zealand mental health nurse, psychotherapist and psychodramatist, created one such model in the 1980s. Labelled the 'Role Development Model' this approach has its foundations in role theory and psychodrama.[26] Paul Spurr, an Australian mental health nurse who trained extensively with Consedine, subsequently developed 'Clinical Supervision for Role Development Training' in[56] response to organisational needs. The training was initially provided for mental health nurses, however, a range of health professionals, including midwives described in this study, have accessed this training to prepare them for the facilitation of individual and/or group CS.

1.1. Study context

In 2007, the Nursing and Midwifery Office (NaMO) in the state of New South Wales (NSW), Australia held two midwifery workforce forums in an attempt to identify strategies that might better support the professional development of midwifery workforce and improve recruitment and retention, particularly in rural and regional areas. Clinical supervision was nominated as a major element of support that should be available to midwives and midwifery students. As a result, the health department committed to funding 100 midwives to undertake 'Clinical Supervision for Role Development Training'. The eight-day training was provided at six regional locations in NSW during the period 2008–2011, with midwives attending from a number of Local Health Districts (LHDs). Eleven midwives completed the training held in Northern NSW LHD in 2009, with completion by a further seven midwives in 2011. There was an expectation that these midwives would then be accessible to provide CS for other midwives in the LHD.

Initially the trained supervisors shared information about CS through in-service sessions, posters and invitation letters. Trial sessions were also offered to raise awareness of the concept. The LHD then introduced a caseload model of midwifery care with clinical supervision incorporated as part of the midwives' hours, fueling further interest. One of the trained midwives was funded to provide CS sessions and the supervisee could attend in work time; sometimes with cover from colleagues or educator if available and in own time using time-in-lieu. As more midwives became familiar with the concept many attended in their own time.

There was anecdotal evidence from the participating midwives that CS was potentially valuable to support midwives, however, there has been little formal evaluation or research exploring the perceptions and experiences of midwives receiving CS. The