Australian College of Mental Health Nurses | Australian College of Midwives | Australian College of Nursing

Discussion Paper: Clinical Supervision for Nurses and Midwives

Clinical Supervision has an established history in healthcare professions including psychotherapy, counselling, social work, psychology and psychiatry[1], with reference to Clinical Supervision in the nursing literature dating back to 1925[2]. The Clinical Supervision literature continues to expand and the literature base from all disciplines is extensive.

Clinical Supervision is increasingly being regarded as important for all midwives and nurses regardless of what area, role, level, or model of care they work in[3]. The capacity to reflect on practice is a desired aspect of nursing and midwifery[4-6] and has been identified as a core characteristic of the expert midwife and nurse[7].

The evidence that Clinical Supervision is not only an important professional reflective practice activity, but also an impactful professional support strategy for nurses and midwives, continues to grow. Nurses and midwives engage in discussion and research into Clinical Supervision and since the original version of this Position Statement there have been at least 113 peer reviewed articles relating to Clinical Supervision for midwives (18) and nurses (95).

Systematic reviews of Clinical Supervision in nursing have been undertaken in relation to advanced practice[8], nurse educators[9] remote and primary care [10], child and family health[11], person-centred practice[12], palliative care[13, 14], oncology[15], mental health [16-18], and nursing and midwifery[19, 20]. In addition, effective Clinical Supervision[21], peer groups[22], supervisor training[23, 24] implementation[20, 25], the impact of COVID-19[26], organisational outcomes and wellbeing [27-29] have been reviewed.

Research studies have examined Clinical Supervision in specific contexts including critical care[30, 31], emergency[32], trauma nursing[33], graduate and advanced practice[34-36], peer groups[37], breast care[38], district nursing[39], midwifery[40-42], palliative care[43, 44], mental health[45-58], and intellectual disability[59].

Discourse has continued through at least 51 presentations at conferences organised by the Colleges collaborating in this Position Statement. References to reflection and Clinical Supervision in nursing and midwifery are appearing on professional websites and in publications[60-64]. The Nurse Midwife Health Program Australia is a national service launched in 2024[65] and has clinical supervision included in their suite of professional supports[66]. Queensland[67] and the Australian Capital Territory[68] have published frameworks on Clinical Supervision for nurses and midwives and Clinical Supervision has been a regular focus of discourse in relation to mental health nursing with recent activity in Victoria[69], Queensland[70], Western Australia[71], South Australia [72], and Tasmania[73].

Despite this increased level of professional interest and activity, the term *Clinical Supervision* is not recognised and understood by some nurses and midwives and continues to present a barrier[8, 25]. To address this misunderstanding and continue to raise awareness of the positive benefits of this professional development strategy, it is

important to clarify the terminology as it is used in this Position Statement and Discussion Paper.

Definition

Clinical Supervision is a formally structured professional arrangement between a supervisor and one or more supervisees. It is organised around a purposefully constructed regular meeting that encourages critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice. The supervisor facilitates the supervisees to critically examine their work issues to gain a deeper understanding, consider alternative perspectives, develop insights, and where required, determine what next steps need to be taken. Clinical Supervision facilitates development of the reflective practice and professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace.

Clinical supervision as it is applied here is distinct from:

- Point-of-care Supervision[31] that occurs in the clinical setting such as clinical teaching, buddying and preceptorship.
- Clinical Supervision that is an integral part of educational programs with relational practice at their core such as counselling, psychotherapy, psychology and psychiatry. The primary difference is that this type of Clinical Supervision supports trainees in developing practice skills and includes an evaluative component contributing to their entry into the relevant profession[74, 75].
- Supervised Practice as defined by the Australian Health Practitioner Regulatory Agency and the Nursing and Midwifery Board of Australia76 that forms part of regulatory processes.
- Delegation and supervision of nursing activity to enrolled nurses and others as per the Nursing and Midwifery Board of Australia Standards for Practice[77].
- Mentorship, Peer Review, and Professional Coaching as these have their distinct histories and processes[78-80].
- Operational and Clinical Management Processes which focus on governance[81-83].
- Personal Staff Support Services focussed on personal wellbeing.

See glossary for further detail.

This Position Statement and Discussion Paper:

- Uses the term ***Clinical Supervision*** in recognition of its long history,
- Accepts that ***Reflective Practice Groups***[49, 88, 89] are a form of group Clinical Supervision and the evidence from research in this area informs these documents.
- Utilises ***Clinical Supervision (Professional)***[81] to identify Clinical Supervision provided within educational programs and recognises the important contribution it makes to the literature and development of Clinical Supervision
- Acknowledges that ***Clinical Supervision (Reflective)*** may be preferred by some midwives and nurses[61, 71] but it is important to note that Clinical Supervision is more than reflection alone.

Modes and models

Modes

Clinical Supervision can be conducted via a range of modes. These include meeting in dyads (one-to-one) or small groups (2-8 supervisees), which can be face-to-face, by telephone, or video-conference (via an agreed online platform). Since the COVID-19 pandemic, online platforms have been increasingly and successfully used[46]. In addition, Clinical Supervision can be provided between peers[37, 41, 90], and between disciplines[91, 92].

Models

Within Clinical Supervision practice there are two main groups of models: *psychotherapy-based models* and *supervision-specific models*[93]. Psychotherapy-based models utilise the assumptions and techniques embedded in a psychotherapeutic approach to guide Clinical Supervision. Supervision-specific models have been developed over time based on Clinical Supervision programs for the helping professions[93]. Beddoe[94, p.89] states that:

> Although each profession has its own unique corpus of knowledge and skills, supervision of health and human services professionals is grounded in theories and practices common to all.

This Position Statement and Discussion Paper do not prefer a mode or model of Clinical Supervision as there is no evidence for the superiority of any approach[75].

Components of effective clinical supervision

There is substantial evidence that a trusting professional alliance between the supervisor and supervisee(s) is the core element of effective Clinical Supervision. The following components contribute to the developing and maintaining this alliance[8, 12, 15, 17, 19, 22, 25, 45, 56, 58, 95-103] and underpin effective Clinical Supervision.

Clinical Supervision:

- Is conducted in regular, private and protected time, away from the practice setting.
- Incorporates effective communication and respectful feedback.
- Is supportive, facilitative and focused on the work issues the supervisee(s) brought to the session.
- Maintains a focus on improved quality of service to health consumers.
- Is an opportunity to talk about the realities, challenges and rewards of practice and to be attentively heard and understood by a specifically trained professional.
- Facilitates supervisee self-monitoring and self-accountability and involves the supervisee learning to be a reflective health professional.
- Develops knowledge and confidence with a strengths-based focus aimed at building supervisee practice skills, self-awareness and understanding of themself as a helping professional.
- Is a culturally safe and respectful relationship that has commitment from both the supervisor and supervisee(s).
- Is predictable in that supervisee(s) know what to expect with consistent, thoughtful and clear structures, boundaries, processes and goals.
- Is supported by an agreement that is reviewed regularly.
- Is confidential within the ethical and legal boundaries of nursing and midwifery practice[77, 104-106].
- Supports supervisees to choose their supervisors.
- Is provided by professionals who have undertaken specific training in Clinical Supervision and engage in their own regular Clinical Supervision.
- Is not provided by a professional who has organisational responsibility to direct, coordinate or evaluate the performance of the supervisee(s).

Culture and diversity

The Australian community is diverse comprising of a mix of cultures, languages, abilities, gender identities, and sexual orientations. Midwives and nurses provide services to this community which includes many disenfranchised and marginal groups. The importance of culture to health and wellbeing is recognised, and in particular the impact of colonisation on Aboriginal and Torres Strait Islander peoples[77]. Therefore, Clinical Supervision is culturally embedded and as such, cultural perspectives of health consumers, supervisees, supervisors and the over-arching health system must be considered.

Cultural humility as applied to Clinical Supervision has been defined as:

> a way of being that involves a willingness, an openness and desire to (a) reflect on oneself as an embedded cultural being and (b) hear about and strive to understand others' cultural backgrounds and identities[101, p. 549].

Conversations in Clinical Supervision about cultural issues that deepen understanding and build a trusting professional alliance are more likely to occur when there is an openness to reflect in this way. Similarly, when supervisees bring their cultural humility to their work with health consumers, their work with them is strengthened[101].

There are many ways to increase cultural awareness; for example the peak advocacy body for Aboriginal and Torres Strait Islander Nurses and Midwives in Australia[107] offers programs that support understanding of cultural safety. Programs such as this support practice and Clinical Supervision.

Outcomes

Outcomes for supervisees

A substantial literature base on Clinical Supervision has accumulated over many years and numerous evaluation studies have been conducted in a range of settings. It is known that nurses and midwives who engage in Clinical Supervision overwhelmingly report positive benefits for their practice and wellbeing. These studies are predominantly qualitative but more quantitative and mixed-method studies are emerging with many of the findings consistent over time[95]. Surveys, rating scales, focus groups and semi-structured interviews have been used to evaluate the impact of Clinical Supervision, provided individually and in groups, on supervisees.

The benefits identified from the experiences of supervisees are summarised as follows[8, 12, 15, 17, 19, 21, 22, 29, 44, 45, 52, 53, 56, 89, 95, 103, 108-113]:

- Increased self-awareness and understanding of ourselves as helping professionals.
- Development and utilisation of skills, a deeper theoretical knowledge and linking theory and practice.
- Increased competence, confidence, self-efficacy, professional accountability, and sense of empowerment and autonomy.
- Supported idea generation, creativity, innovation, problem solving and solution generation.
- Improved understanding of professional, moral and ethical issues.
- Improved coping at work and general wellbeing; improved identification of, and access to supports; and reduced stress, anxiety and burnout.
- Increased job satisfaction, personal accomplishment and development.
- Improved collegiate relationships (including with managers) and reduced conflict.
- Increased interest and engagement in work, and commitment to the organisation.
- A sense of community and increased trust.
- Role clarity and a stronger sense of professional identity.
- Increased interest and engagement in work, job satisfaction, personal accomplishment and development.
- Improved ability to engage therapeutically, to listen, support, empathise and understand the experiences of health consumers.
- Increased ability to maintain hope, respect individuality and autonomy and engage health consumers in their own recovery.
- Increased critical thinking, critiquing and improving practice including risk management.
- Feeling supported by having thoughts and feelings listened to.

While Group Clinical Supervision can be very effective[22, 89, 90, 111, 114, 115], the complexities of this mode of Clinical Supervision must be considered prior to implementation. For example, anxiety can be experienced more intensely in a group, particularly in the early stages and trust can be slow or difficult to develop[89, 112, 116]. In addition to clinical supervisory skills, it is essential for group supervisors are skilled in group process and group Clinical Supervision[45, 89, 111, 117]. While it can seem cost-effective and pragmatic for inpatient and team groups, these settings can be challenging given they are busy work environments where workload pressures can make it difficult for staff to get to Clinical Supervision[118]. Team dynamics, changing group composition and the lack of option for

self-selection into a group impact the quality and effectiveness of Clinical Supervision[19, 20, 119].

It is important to note that negative or neutral outcomes of Clinical Supervision have been reported but to a significantly lesser degree than positive outcomes[95]. Negative experiences include lack of trust, intrusiveness, unintended disclosure of personal information, breaches of confidentiality, bullying, feelings of doubt, shame, fear of judgement and being seen as not coping, and frustration with the loss of focus on the health consumer[103, 109, 119-123]. Negative experiences have been associated with poor supervisory relationships, absence of key competencies within supervisors and lack of distinction between Clinical Supervision and operational processes[94, 124]. Ineffective or inadequate Clinical Supervision can be counterproductive, detrimental to development, unethical, and harmful to supervisees[94, 124-126]. It is therefore imperative that implementation strategies are considered to ensure nurses and midwives are supported to give and receive effective Clinical Supervision.

Outcomes for health consumers

Determining measurable links between Clinical Supervision and outcomes for health consumers poses an ongoing problem within research designed to measure the effectiveness of Clinical Supervision and criticisms of the limited available evidence have included poor methodology and scientific rigour[75, 113].

However, some progress is being made, particularly in examining the working alliance between the supervisor and supervisee[127, 128]. There is a current body of work designed to determine if and how this alliance leads to skill development within the supervisee and subsequently impacts on health consumer outcomes[129]. The concept underpinning these studies is that a positive and strong alliance between a supervisor and supervisee can enhance the therapeutic skills of the supervisee working with health consumers. Bordin[127] developed the concept of the Therapeutic Working Alliance (TWA) between a therapist and client as a collaborative change relationship that included the triad of an agreement, identified tasks or goals, and a relational bond. He applied this thinking to the clinical supervisory relationship[128] and named the relationship that develops between a supervisor and supervisee as the Supervisory Working Alliance (SWA). Both the TWA and the SWA can be measured and this was utilised in a study of people with depression who received counselling from supervised therapists utilising the working alliance model[130]. It was found that Clinical Supervision "can play a role in developing the working alliance and enhancing treatment outcome"[130, p.327]. A more recent study demonstrated that a stronger SWA was associated with improved health consumer outcomes, in particular, a reduction in their distress levels[131].

A study using a systems psychotherapy approach to Clinical Supervision was linked with improved outcomes for families, with particular impacts on collaboration, autonomy, empathy, clarity of concerns, child focus and purposefulness[132]. Another study found that an adult mental health facility with embedded effective Clinical Supervision processes that were supported by management was linked with increased health consumer satisfaction with the care and the quality of the facility[133]. The severity of

positive symptoms of people with schizophrenia decreased significantly in a group being cared for by mental health nurses who received Clinical Supervision in comparison to a group cared for by mental health nurses who did not have Clinical Supervision as part of their Psychosocial Intervention training course[134].

Outcomes for organisations

While the benefits of Clinical Supervision to health consumers are important to organisations, so are outcomes for supervisees. The association between regular Clinical Supervision its impact on burnout, wellbeing, job satisfaction, and retention and the overall work environment has been a recurrent theme in research findings[8, 11, 19, 27-29, 40, 44, 89, 114, 135-138]. This is important for organisations to consider given there is a clear link between stress, burnout, workplace culture and workplace support, with an increase in adverse events[139-143]. In addition, strategies that contribute to improved professional functioning and wellbeing of nurses and midwives should be of particular interest to organisations given there have been longstanding concerns about the health and wellbeing, recruitment and retention, and subsequent workforce shortages of nurses and midwives[144, 145]. These concerns have become more acute since the start of the COVID 19 pandemic[138, 146-148].

A recent scoping review of the outcome literature on workplace-based Clinical Supervision for human service organisations between 2011 and 2021 found it was "an organizational resource to alleviate the negative impacts of emotional labor and job demands while increasing job satisfaction" and was a worthwhile investment [109, p.36]. However, the authors identified need to further an understanding of what approaches are effective in producing positive outcomes for healthcare workers and organisations.

The National Health System in England is implementing a strategy, initially developed for midwives[149] and now for nursing [150] called the A-EQUIP model. This works by:

- Advocating for the patient, the nurse and healthcare staff.
- Providing Clinical Supervision using a restorative approach.
- Enabling nurses to undertake personal action for quality improvement.
- Promoting the education and development of nurses.

Publications emerging from this work are chronicling its development, highlighting the challenges to implementation and demonstrating its potential benefits to the workforce[30, 42, 151-166].

Orientation, Education and training

To embed Clinical Supervision into nursing and midwifery practice, education should begin at undergraduate level. Students need to be introduced to the concept early in their education as part of a suite of strategies that support them professionally[167]. For nurses and midwives to make the most of their supervisory experiences, they need to be educated on how to be a supervisee, what Clinical Supervision is and is not, and how to

use and evaluate Clinical Supervision[17, 25, 168]. Being a supervisee is not a passive role[87] and supervisees need to be orientated to the process and be clear about their rights and responsibilities and what they can expect from a supervisor[8].

Upon entry into the workforce, nurses and midwives need to be orientated to local Clinical Supervision policy and procedures including how to access it[69, 87, 97, 119, 169, 170].

Particular skills, knowledge and attributes have been repeatedly associated with effective individual and group Clinical Supervisors and it is agreed that supervisors require specific training programs in order to practice effectively and safely[15, 20, 24, 25, 45, 86, 87, 94, 97, 102, 111, 169]. Without training, the Clinical Supervision provided is more likely to be inadequate, counterproductive or harmful[94]. Without the availability of clinical supervisor education programs, suitably educated clinical supervisors will not be available to embed Clinical Supervision into practice[118, 171].

Two recent systematic reviews have provided further information about clinical supervisor education programs for counselling, psychology, social work[172] and health and human services[173]. Programs included in both reviews described the utilisation of a variety of learning approaches such as didactic (presentations, videos, reading), active (group discussions, case studies, reflection activities), and experiential (role play, practice sessions with feedback, group supervision). In addition to Clinical Supervision theory and practice, programs incorporated adult, social, and reflective learning theories, and were provided face-to-face, online, or as a hybrid of both. The training was generally received positively by participants[172]. The mixed training methods supported social learning and led to improved knowledge and skills, as well as increased satisfaction and engagement of participants as long as participants were provided with protected time to attend[173].

Three papers from the Australian healthcare setting not included in either of these reviews are worthy of mention[23, 24, 174]. The findings of these studies have many similarities to the above reviews as they highlighted the importance of education being provided in a safe and supportive manner that utilises a range of educational approaches that maximise learning "through ongoing supervisor reflexivity paying attention to facilitator-supervisor relationships, as well as protected time for supervisors to translate learning into practice"[23, p.1]. A fourth Australian paper describes an 'apprenticeship' training program for facilitators "that includes an introductory workshop, 'in-group' training with an experienced facilitator, and monthly facilitator supervision sessions"[89, p.32]. All Clinical Supervisors need to maintain their reflexivity through their own Clinical Supervision [104] so they can receive professional support for the work they do, be a role model and build their competency in the provision of Clinical Supervision.

The available literature highlights the need for further research that explicates the components of educational programs that produce effective clinical supervisors to provide Clinical Supervision to the midwifery and nursing workforce.

Implementation

Implementation strategies must be considered carefully and there is overwhelming consensus in the literature that strong and consistent organisational support must be provided for successful implementation and sustainability of Clinical Supervision[14, 17, 20, 69, 83, 102, 175, 176].

Implementation strategies include:

- A clear and consistent approach to Clinical Supervision supported by orientation and education processes.
- Clinical Supervision included in a strategic plan and governance processes.
- Adequate initial and ongoing resourcing with a sufficient budget allocation and access to expertise.
- Evidence of commitment at all levels of the organisation.
- Support of managers who are integral to facilitating staff to receive and give Clinical Supervision.
- Ensuring the provision of managerial supervision that is distinct from Clinical Supervision.
- Clear policies and procedures that align with this Position Statement and Discussion Paper.
- Audit and evaluation processes.
- Availability of clinical supervisor education programs with ongoing support and professional development opportunities for nurses and midwives who take up the supervisory role.
- Dedicated information systems and documentation processes.
- Supported rostering to facilitate staff attendance at Clinical Supervision.
- Protected time for midwives and nurses to attend education to become Clinical Supervisors, and to receive ongoing practice support and their Clinical Supervision.

Standards are being developed as part the implementation of the Clinical Supervision for Mental Health Nurses: A Framework for Victoria[69] with the aim of completion by the end of 2024. It is planned that this will be tabled for national consideration. These include standards for supervisees, supervisors, organisations, and education programs and will provide a benchmark for individuals, groups and organisations to audit Clinical Supervision against agreed parameters.

Evaluation and research

Evaluation

Evaluation is recommended at a supervisor-supervisee level with regular feedback between supervisor and supervisee(s) and identified time frames for formal review (included in the agreement) to ensure the Clinical Supervision relationship remains effective[177]. A study undertaken in New Zealand found that evaluation tended to be informal, largely ad-hoc and primarily instigated by the Clinical Supervisors[96]. The participants in this study viewed organisationally driven evaluation with suspicion and this needs to be considered given it is recommended that evaluation of Clinical Supervision is undertaken by organisations against locally agreed measures[87]. Ascertaining the perspectives of supervisees, supervisors and management helps ensure that the quality and efficacy of local Clinical Supervision arrangements can be demonstrated and regularly reported[133]. Determining workforce engagement with Clinical Supervision can be partly ascertained through record audits such as numbers receiving Clinical Supervision, frequency and duration[87, 133]. Economic benefits can be evaluated through reviewing sick or stress leave, work cover, retention and critical incidents and adverse events[87]. Finally benefits to practice may be found through reviewing service user satisfaction and complaints[87].

Research

Criticism of the quality of the research into Clinical Supervision has been highlighted[75, 96, 98, 103, 113, 178]. This is not surprising given that Clinical Supervision is complex and there are a multitude of confounding variables that make research very challenging and:

> as a result of the complexity and diversity of the contexts in which it is implemented, the literature reports confusion about the role and structure of clinical supervision; a diffuse unlinked evidence base; challenges measuring the effectiveness of clinical supervision and difficulty in implementing clinical supervision in practice[179, p.22].

A review of Clinical Supervision research reviews over the last 25 years concluded that the methodological problems of the 1990s are still apparent[75]. Research rigour is limited by a lack of common denominators and detail regarding the structure and process of Clinical Supervision. For example, definitions, goals, models, session content, supervisee and supervisor training, what phenomena are examined, context, implementation processes and research instruments used[95, 98, 179-182] are often not described well. This means making comparisons and reaching definitive conclusions difficult.

However, it was identified that there is “a growing and lively research interest”[75, p.203] in Clinical Supervision particularly apparent in the last 15 years.

This is also demonstrated by the initiation of the Clinical Supervision Research Collaborative (CSRC) which is:

> a forum, a learning hub for all those interested in advancing the practice of clinical supervision around the globe. CSRC Collaborators (members) include both scientists and practice professionals…Together, our clinical supervision researcher and practitioner Collaborators work to address the perplexing, nuanced, and fascinating questions that can advance the science and practice of clinical supervision. They also assist each other in advocating for standards that promote resources needed to allow supervision practitioners to employ best practices in their work.

The CSRC provides important support to researchers as the difficulties in designing, conducting, and funding[183] well-constructed research that identify the structure, process and outcomes of Clinical Supervision[182] remain. Outcome-orientated research must include outcomes for those who use the services of the supervisees, for the supervisees themselves and as for organisations and the profession[182]. For this to occur, professional bodies, the educational sector, organisations, funding agencies, and clinicians must consolidate efforts to improve the evidence base for Clinical Supervision.

Glossary

Clinical Supervision (Professional)[81]***:*** forms part of educational programs and has an evaluative component that contributes to the determination of the trainee's entry into a body of professionals such as psychotherapists, counsellors, psychologists, and psychiatrists. While the evaluative component may represent a power difference, this needs to be understood and managed[74, 75, 94].

Reflective Practice Groups: are a form of group clinical supervision led by a trained facilitator, "where clinical narrative is explored in a supportive environment that promotes reflection, allowing participants to share professional, clinical, ethical, and personal insights relevant to nursing [and midwifery] practice"[88]. There is a focus on the personal and interpersonal aspects of healthcare, supporting to participants, promoting skilled interpersonal communication, and positively impacting workplace culture thereby contributing to positive health consumer outcomes.

Point-of-Care Supervision

Clinical Teaching: is referred to with a range of titles that are used to describe nurse and midwife educators who "…play a critical role in the lifelong professional development of all nurses [and midwives] and in maintaining and advancing nursing [and midwifery] practice standards"[9, p.1]. They are based in the clinical setting and contribute to the professional development of midwives and nurses in a hospital or healthcare setting[184].

Preceptorship: a relationship constructed to link experienced nurses / midwives (preceptors) with students, new graduate nurses / midwives, or new staff (preceptees) to facilitate their orientation and integration into their new roles and responsibilities in the professional practice environment of care[185].

Buddying: is a type of clinical educator but is not required to undertake professional development role. A student or staff member that is new to the clinical setting is allocated (usually by the unit manager) to work for a shift with a buddy to support their orientation into that setting[186].

Other forms of facilitated Professional Development

Peer Review: is a formalised quality improvement process where assigned reviewers provide constructive feedback to a peer of the same level, comparing practice against standards or guidelines. Nurses and midwives become active participants in monitoring and improving each other's practice and it requires them to be purposefully engaged in observing, evaluating and discussing their own work[79].

Professional coaching: "…partnering in a thought-provoking and creative process that inspires a person to maximize their personal and professional potential. The process of coaching often unlocks previously untapped sources of imagination, productivity and leadership"[80].

Mentoring: can be a formal or informal arrangement where an experienced and knowledgeable midwife or nurse (mentor) is paired with a student or less experienced

midwife or nurse (mentee) to improve and nurture their skills, knowledge and expertise[78].

Clinical Management Processes

It is a managerial responsibility to ensure that robust Clinical Management Processes are in place to review clinical work and provide direction and guidance to staff to support them to deliver high-quality services and effective outcomes for health consumers. Processes include formal/informal clinical consultation sessions, clinical governance meetings, audit meetings and risk management meetings clinical reviews, handovers, grand rounds, case presentations and clinical team meetings[69, 70].

Operational Management Processes

Operational Management Processes aim to ensure the organisation's goals, standards, procedures and guidelines are being maintained and the service outcomes are being achieved[81].

Managerial Supervision: This forms part of operational management processes usually undertaken by the nurse/midwife's line manager who reviews both the quality and quantity of the work (generally in relation to key performance indicators) and includes instruction, direction evaluation and governance [81, 82]. These processes place responsibility on the organisation and the line manager "…for ensuring that staff undertake the tasks delegated to them in a satisfactory manner"[81].

Performance Review: involves the manager evaluating the work performance and setting goals for the following year. It is a structured process driven by organisational requirements[83]. This is best done through a collaborative and continuous process with regular meetings between staff member and manager.

Operational Team Meetings: provide a regular forum for reviewing team functioning and addressing team issues as required.

Personal Staff Support

Personal staff support services are provided by the employer to support the emotional, mental and general psychological wellbeing of its employees and their immediate family members[84]. Services provided can include critical incident stress support, educative services that support self-care as well as Counselling and Psychotherapy.

Counselling and Psychotherapy: are relationship-based services provided by specifically educated health professionals that aim to assist people to restore their psychological health and grow personally[85-87].

Supervised Practice

Supervised Practice forms part of the regulatory processes applied by the Australian Health Practitioner Regulation Agency[76] and the Nursing and Midwifery Board of Australia (NMBA). Supervised Practice can relate to aspects of registration process or form a condition imposed by the NMBA in response to a notification or complaint[76].

This Discussion Paper was developed by representatives from each college.

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