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New evidence in the implementation and evaluation of Clinical Supervision

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PRESENTATION PLAN:

- Introduction
- Implementation
- Evaluation
- Recommendations

  -Implementation
  -Evaluation

- Summary
- Key references

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Northern
Territory

Queensland

Western Australia

Brisbane

South Australia

New South Wales

Perth

Adelaide

A.C.T

Sydney

Victoria

Melbourne

Tasmania

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INTRODUCTION:

- Clinical Supervision [CS] is the provision of time-out for nurses, and an opportunity within the context of an ongoing professional relationship with an experienced practitioner, to engage in guided reflection on current practice, in ways designed to develop and enhance the practice in the future

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In practical terms, this often means:

- Small groups [n=~6] of Supervisees meet with trained Clinical Supervisor [or in dyads]

- 45-60 minutes per session, monthly frequency

- Facilitated, reflective discussion, in confidence, around matters of professional relevance and importance

- CS is not Personal Performance Review, or Case Review, or Therapy

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Benefits of CS* have been claimed for:

- Nurses [increased levels of self-esteem, morale, job satisfaction, enhanced skills and knowledge, greater personal and professional development]

- Patients [improvement in standards of care delivery, increase in effective interdisciplinary communication]

- Organisations [reduction in absenteeism and staff turnover rates, kudos arising from innovative practices]

- Empirical basis for many of these claims remain unsubstantiated

  * Often referenced to early, small, Scandinavian studies

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- Before 2000, few rigorous quantitative CS evaluations had been undertaken

- Clinical Supervision Evaluation Project; 586 respondents in 23 centres in England and Scotland, United Kingdom

- Established the essential contours of Clinical Supervision in Britain and provided an informed view of existing assessment tools to measure the impact of CS

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- The Manchester Clinical Supervision Scale$^©$

- ~100 MCSS$^©$ licensed evaluations, in 13 countries worldwide; authorised translations into 7 languages, other than English [Spanish, Swedish, French, Norwegian, Danish, Portuguese and Finnish]

- 7 MCSS$^©$ subscales tapped into 3 domains of the most influential model of CS
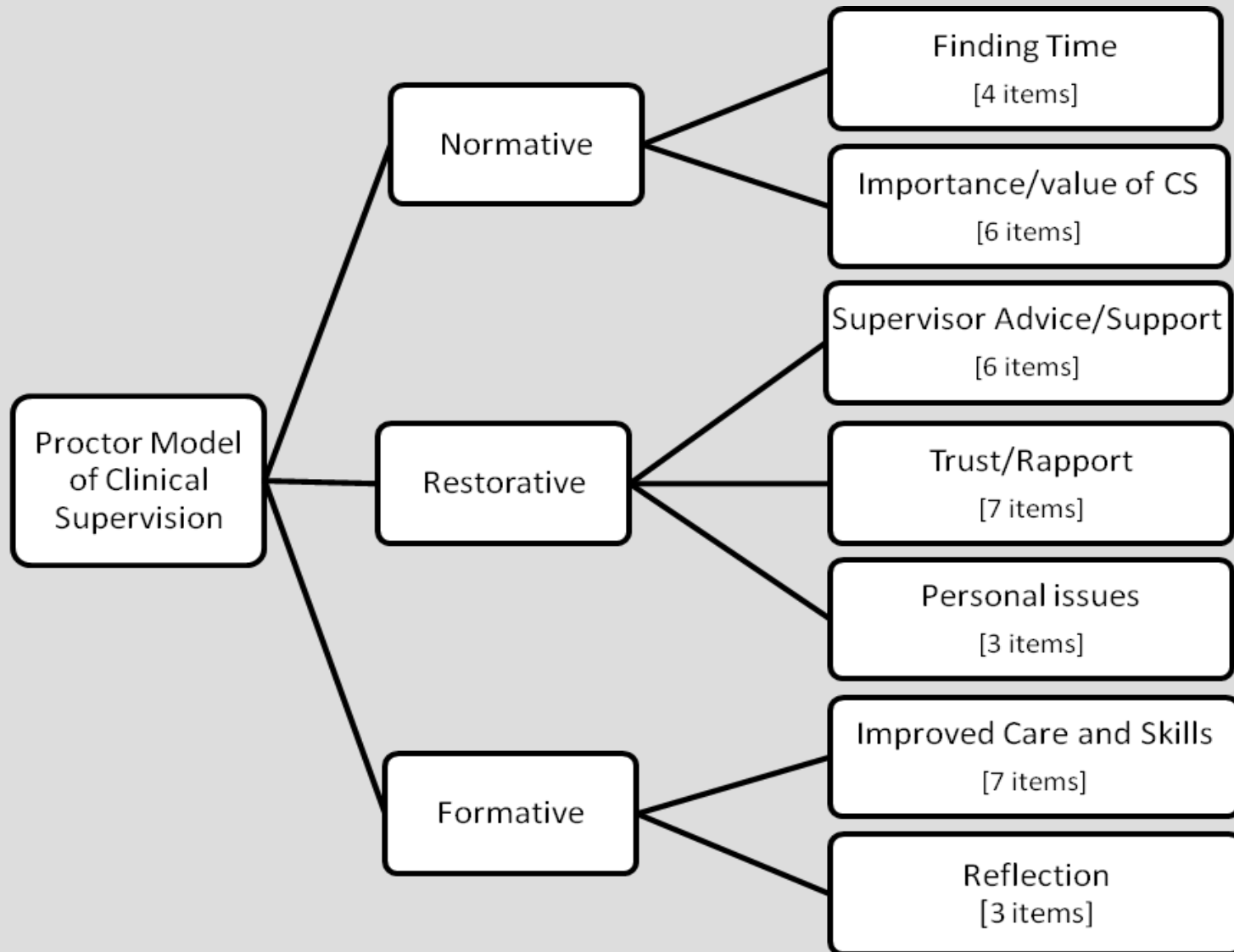
Dr Edward White   Brigit Proctor

London, September 2009

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Proctor Model

- **Normative domain** [promotion of standards and clinical audit issues]

- **Restorative domain** [attention to personal wellbeing of the Supervisee]

- **Formative domain** [development of knowledge and skills]

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Sympathetic set of relationships between:

- Important contemporary clinical issue [CS]
- Operational definition [Open University]
- Conceptual model [Proctor]
- Dedicated research instrument [MCSS©]

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IMPLEMENTATION:

- Pragmatic randomised controlled trial [RCT] of Clinical Supervision [funded by Queensland Treasury; A$248,000]

- Joint CIs [EW & JW]; Project Research Officer, CS trainer and 3 Area Coordinators

- RCT sited in 17 adult mental health facilities, in 9 participating locations across Queensland; inpatient and community, public and private, regional and rural settings [furthest locations 1800kms apart]

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Quantitative data collection methods:

Copyright outcome measures, all with well established psychometric properties, at three levels:

- Mental Health Nurse –GHQ[28], MBI, SF8, NWI-R, MHPP-R, MCSS [baseline and 12 months]

- Patient –SAQ, PCSQ [baseline, 6 and 12 months]

- Unit staff –PUQ [6 monthly]

+ Unit data –sickness, turnover, adverse events, complaints [baseline, 6 and 12 months]

Intervention arm of the RCT:

- 4-day intensive, experiential, residential Clinical Supervision training course, hosted in beachfront hotel conference facilities on the Sunshine Coast, Queensland

- Trainee Supervisors [n=24]; 17 female, median age 46yrs, Nurse 21yrs, MHN 17yrs

- Post-course evaluation completed [well reviewed; demonstrably efficacious]

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Participants at baseline:

- Intervention Arm [n=9 sites]

  Mental Health Nurses [Supervisors n=24; Supervisees; n=115]; Patients [n=82]; Unit staff [n=43]

- Control Arm [n=6 sites]

  Mental Health Nurses [n=71]; Patients [n=88]; Unit staff [n=11]

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Main results: [from analysis of *quantitative* data]

- No statistically significant differences were found in the demographics [age, sex, grades…] between MHNs allocated to the Intervention and Control Arm locations

- For MHNs in the Control Arm, no statistically significant differences were found on any of the research instruments, over time, during the 12 months of the RCT

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Supervisors:

- Supervisor Total MCSS$^©$ scores at the end of the CS course were significantly higher compared with their perception of CS at baseline

- The significant difference was maintained after 12 months supervisory experience

- Two subscales revealed particularly significant differences; Trust and Rapport and Importance/Value

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- High MCSS© scores were found to be significantly associated with low MBI© emotional exhaustion scores $[R_s=-0.434, P=0.002]$

- That is; the better the CS, the less burnt out staff reportedly felt

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Supervisees:

- In 6 of 9 RCT Intervention Arm locations, Supervisees experience of CS met or exceeded their expectations, between baseline and twelve months

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- *Overall*, Supervisee MCSS$^©$ Total scores did not change significantly over the 12 months of receiving Clinical Supervision

- However, the MCSS$^©$ subscales associated with Proctor's Normative and Restorative domains *did* increase significantly

Theoretical proposition #1:

- Significant changes in the Formative domain [development of knowledge and skills] may only become demonstrable **after** changes to the Normative [promotion of standards and clinical audit issues] and Restorative [personal wellbeing] domains have become established, caused by sustained and efficacious CS

Theoretical proposition #2:

Overall median MCSS$^©$ Total Scores in RCT were identical to that in secondary analyses of merged international MCSS$^©$ data sets:

- Median score=136 [range 36-180]

- Indicated benchmark for demonstrable efficacy of Clinical Supervision

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- In RCT, significantly *more* Supervisees who scored *less* than the MCSS© median value [136] moved into GHQ© 'psychiatric caseness', over time

- Whereas, there was no significant change in the level of 'psychiatric caseness' for those that scored *more* than 136

Theoretical propositions #3:

- Only *demonstrably efficacious* CS will make a contribution to Supervisee's wellbeing, whereas sub-optimal CS will not

- CS has the potential to inoculate against stress

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Patients:

- *Overall*, statistically significant differences in quality of care and patient satisfaction could not be demonstrated, for the data collected during the RCT

  However:

- The absence of evidence, is not evidence of absence

- In one RCT location, *all* outcome measures moved in a positive direction

- Location was a *private sector* mental health service provider

EVALUATION:

- All clinical practice development should be evaluated, modified [when necessary] and re-evaluated

- The Manchester Clinical Supervision Scale© is the leading CS measurement instrument

- Like most psychological measurements, the MCSS© uses an *ordinal* scale

- Ordinal scales describe the *order* of scores

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- Therefore, a difference between scores of 1 and 2, may not be the same as between 3 and 4, and should not be assumed to be so

- When using an *ordinal* scale, means and standard deviations, may not have validity*

- Many *ordinal* scales are wrongly used as if they provide *interval* level measurement

- When this is so, the use of most parametric statistics is inappropriate

*Stevens S [1946] On the theory of scales of measurement. Science, 103:2684, pp677-680

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- Rasch Analysis* was developed to test a scale against a mathematical measurement model

- Assesses how well each question behaves in accordance with the rest of the questions in that scale

- Provides a range of fit statistics to check whether adding together the scores of the research instrument is justified, or not

*Rasch G [1960] Probabilistic models for some intelligence and attainment tests. Danish Institute for Educational Research. Copenhagen, Denmark

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- Using real data, amalgamated from several international CS evaluations [n=225 nurses and 160 Allied Health staff] and RUMM 2030 software, the original factor structure and response format of the MCSS$^©$ was tested for goodness of fit to the Rasch Model

- Findings re-confirmed the validity of the response format of the 36-item MCSS©
- They also indicated that original version could be reduced to 26 items with increased structural integrity and resulted in improved fit statistics for 6 subscales [rather than the original 7]
- Justification for a new re-modelled version; MCSS-26© [enquiries@osmanconsulting.com.au]

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- High correlation between MCSS$^©$ scores and MCSS-26$^©$ scores allow longitudinal benchmarking by current licence holders
- MCSS$^©$ score of 136 [indicative threshold for efficacious CS provision] re-calibrated on MCSS-26$^©$ to an equivalent score of 73

Correlation $R_s=0.975$ between the original MCSS© and MCSS-26©
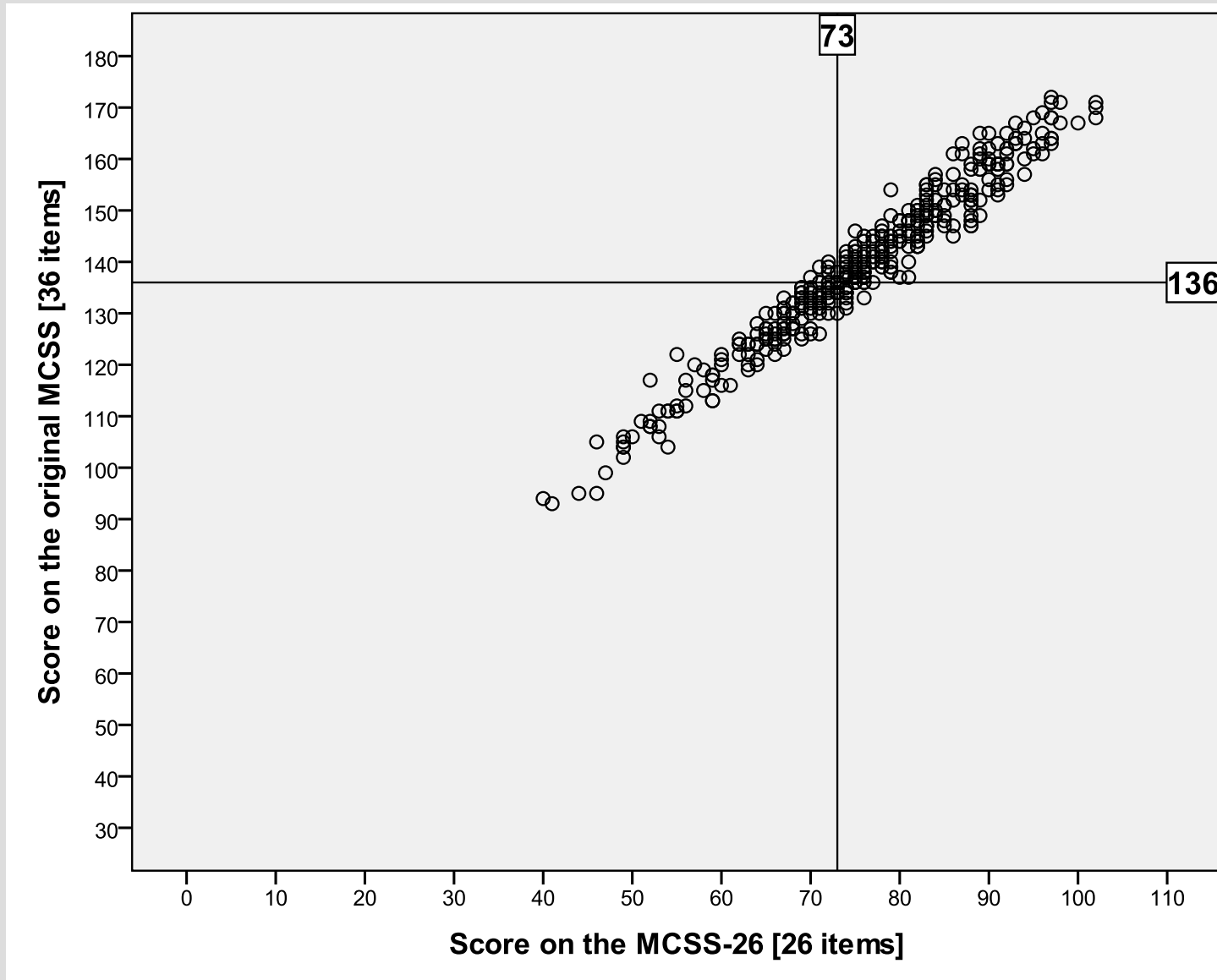
RECOMMENDATIONS: [Implementation]

- Select a single, discrete clinical location
- Agree an explicit, unified, positive position on CS that is owned by *all* levels of management
- Carefully identify and educationally prepare Clinical Supervisors to the standard demonstrated in this pragmatic RCT

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- Recruit *all* nurses in the clinical setting to participate in CS, according to standard protocols [size, frequency, length, ground rules...]

- Maintain Supervisor:Supervisee ratio <1:9

- Retain 90% of Supervisees over the period of data collection [>1 year]

- Support Supervisors through their receipt of regular CS sessions, to ensure efficacious delivery of Clinical Supervision [MCSS-26© ≥73]

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RECOMMENDATIONS: [Evaluation]

- Use a measure designed to evaluate the process/outcome of Clinical Supervision, which has established robust psychometric properties [eg, MCSS-26$^{©}$]

- Accompany with other validated measures, which tap into domains of interest [eg, MBI for staff burnout]

SUMMARY:

- This RCT* has made incremental headway towards establishing the evidence base for the claims made about Clinical Supervision

- MCSS-26© has strengthened the design capabilities of future Clinical Supervision research studies

*One of three studies conducted over the last 30 years, that provide the best and clearest directions for further thought about conducting future successful research in the supervision-patient outcome area [Watkins C E (2011) Does psychotherapy supervision contribute to patient outcomes? Considering 30 years of research. The Clinical Supervisor, 30:2, pp1-22]

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◆ Winstanley J & White E [2011] The MCSS-26©: revision of The Manchester Clinical Supervision Scale© using the Rasch Measurement Model. *Journal of Nursing Measurement*, 19:3, pp160-178 [ISSN: 10613749]

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