








Nature and extent of disruptions to staff clinical supervision practices in health care settings due to COVID-19: A survey study

Priya Martin PhD^{1,2}   | Geoff Argus MPsych (Clin)^{3,4}  | Jordan Fox PhD¹  |
Tiana Gurney PhD¹ | Matthew McGrail PhD¹  | Saravana Kumar PhD⁵  |
Srinivas Kondalsamy-Chennakesavan MPH⁵ 

¹Rural Clinical School, Faculty of Medicine, The University of Queensland, Toowoomba, Queensland, Australia

²Advanced Clinical Educator – Interprofessional, Darling Downs Health, Baillie Henderson Hospital, Toowoomba, Queensland, Australia

³Southern Queensland Rural Health, The University of Queensland, Toowoomba, Queensland, Australia

⁴School of Psychology and Wellbeing, University of Southern Queensland, Toowoomba, Queensland, Australia

⁵Allied Health and Human Performance, University of South Australia, Adelaide, South Australia, Australia

Correspondence

Priya Martin, PhD, Rural Clinical School, Faculty of Medicine, The University of Queensland, Locked Bag 9009, Toowoomba, Queensland 4350, Australia.

Email: priya.martin@uq.edu.au

Funding information

Advance Queensland Industry Research Fellowship; Darling Downs Health, Southern Queensland Rural Health, the University of Queensland Rural Clinical School, and the University of South Australia. Grant number - AQIRF115-2020-CV

Abstract

Objective: To investigate the impact of the COVID-19 pandemic on clinical supervision practices of health care workers in health care settings in one Australian state.

Method: A bespoke survey was developed and administered online using Qualtrics™. The survey consisted of Likert scale and closed questions, with options for free text comments. Numerical data were analysed descriptively and using Chi-Square tests. Textual data were analysed through content analysis.

Results: Of the 178 survey respondents, 42% were from allied health disciplines, 39% from nursing and midwifery, and 19% from medicine. The type and mode (i.e., face-to-face, telesupervision) of clinical supervision prior to the pandemic and at the time of survey completion (i.e., July–August 2021) were similar. Eighteen percent of respondents had a change in supervision arrangements but only 5% had a change in supervisor. For the 37% who changed roles due to COVID-19, 81% felt their current supervisor was still able to support them, 69% were still having their supervisory needs met. Analyses of textual data resulted in the development of two categories: Supervision deteriorating, and some clinical supervision functions (i.e., formative and restorative) being more impacted than others (i.e., normative).

Conclusion: There were substantial disruptions to several parameters of clinical supervision due to COVID-19, that may pose a threat to high quality supervision. Health care workers reported pandemic-induced stress and mental health challenges that were not always addressed by effective restorative supervision practices.

KEYWORDS

clinical supervision, COVID-19 pandemic, health care worker

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial](https://creativecommons.org/licenses/by-nc/4.0/) License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited and is not used for commercial purposes.

© 2023 The Authors. *Australian Journal of Rural Health* published by John Wiley & Sons Australia, Ltd on behalf of National Rural Health Alliance Ltd.

1 | INTRODUCTION

Much has already been documented about the negative impacts of the COVID-19 pandemic on the health care workforce, their well-being and health care delivery processes.¹⁻³ The health care workforce has been significantly impacted from battling a novel virus first identified towards the end of 2019. While the processes for managing the pandemic have become more streamlined, it is estimated that the mental health issues experienced by health care workers are expected to rise into the postpandemic period.⁴⁻⁷ There is no doubt that the pandemic has contributed to some of the longer standing health workforce issues such as burnout and attrition.⁸

It has already been demonstrated that clinical supervision (CS; a professional support mechanism for supervisees to obtain advice, guidance and support from more experienced supervisors, to help them with their roles and responsibilities, and learning)⁹ can have positive effects on health professionals' mental health and well-being, and organisational outcomes such as reduction of burnout and enhanced work satisfaction.¹⁰ These positive staff and organisational outcomes are ultimately expected to improve patient safety and quality of care.¹⁰ Despite these benefits, time pressures have consistently been identified as a significant barrier deterring health care worker participation in CS.^{11,12} It is no surprise that the pandemic created extra workload for health care workers, inducing additional time pressures, thereby posing risks of reduced engagement and participation in effective CS.¹³ Any efforts dedicated to rebooting effective CS practices at the point-of-care need to be informed by objective measurements of the extent and nature of disruptions that have occurred.

The Proctor's model of CS advocates for three CS functions, namely: formative (i.e. skills and knowledge), normative (i.e. managerial, policies and guidelines) and restorative or supportive (i.e. coping with work pressures, stress management and supervisee well-being).¹² Ideally, while supervisees face increased work pressures from complex and/or unexpected circumstances, such as the pandemic, supportive CS functions need to be maximised. However, a recent review of the COVID-19-related CS literature indicates that supportive CS has remained inadequate despite higher rates of mental health challenges experienced by the health care workforce.¹³ Health care organisations need to evaluate the prevalence and effectiveness of CS practices, especially supportive supervision, so as to address any shortfalls. Therefore, this study aimed to investigate the nature and extent of disruption to health care worker CS practices, caused by the COVID-19 pandemic.

What is already known about this subject

- Effective clinical supervision can benefit health care workers, organisations and service users. However, there are numerous barriers such as time and resources that impede health care worker participation in supervision.

What this paper adds

- This study investigated the nature and extent of disruptions caused to clinical supervision because of the COVID-19 pandemic. Numerous areas that need strengthening have been identified to restore effective supervision practices.
- Study findings can help health care workers and organisations to target their efforts in restoring effective supervision practices.

2 | METHODS

2.1 | Design

A bespoke survey was developed to investigate the nature and extent of disruptions caused to health care worker CS by the COVID-19 pandemic.

2.2 | Setting and participants

The study was conducted in Queensland in four regional and rural public health services and four corresponding primary health networks, following the geographical footprint of one of the study partner organisations (i.e. The University of Queensland Rural Clinical School). Eligible participants were those working as doctors, nurses, midwives and allied health professionals (audiology, exercise physiology, medical radiation, music therapy, nutrition and dietetics, occupational therapy, pharmacy, physiotherapy, podiatry, prosthetics and orthotics, psychology, social work and speech pathology) and had been in their role for at least 3 months. While CS practices are variable across professions and organisations, it is commonly mandated or highly recommended by several organisational policies and/or professional registration or association guidelines.

COVID-19 context: Australia recorded its first case of COVID-19 on 25 January 2020 in the state of Victoria. The number of cases grew exponentially to about 360 new cases per day as of 22 March 2020 and started decreasing

to around 26 new cases as of 6 May 2020.^{14,15} Queensland was the first state or territory in Australia to declare a public health emergency on 29 January 2020. School closures came into effect on 30 March 2020, although school remained open to children of essential service workers. The state borders were closed from 26 March 2020.¹⁶ Although the relative impact of COVID-19 was low in Australia, the unprecedented situation triggered a reactive response across different sectors,^{17,18} with restrictions beginning to ease towards December 2021 when the state borders reopened.

2.3 | Outcome measure

A bespoke survey consisting of 37 Likert scale and closed questions, with options for free-text comments, was developed for this study. The survey was piloted with five health care workers and academics prior to being finalised. The questions were designed to understand the nature and extent of disruption or change to CS. Questions broadly focused on the following categories: changes in role and workload, CS prepandemic and during pandemic, CS compliance against professional and organisational standards, supportive functions of CS, adequacy of new CS and telesupervision. Participants were asked to consider their experiences from the onset of the COVID-19 pandemic when answering the survey questions. The survey tool has been included as Appendix S1.

2.4 | Procedure

Data were collected over a four-week period in July and August 2021 through an anonymous survey using Qualtrics™. The survey link was distributed to the study population using email distribution lists of professional and health service networks, newsletters and organisational social media of involved organisations. Three reminders were used to prompt potential participants using the same channels.

2.5 | Data analyses

All numerical data were cleaned and coded using SPSS (version 27). Descriptive statistics were calculated as frequencies and proportions. Chi-squared tests of association were used to compare the type and mode of CS received before the pandemic and now with statistical significance accepted where $p < 0.05$. Free-text comments were collated, cleaned and analysed through a conventional content analysis process by two researchers (PM and JF)

where data were read and re-read several times to develop categories for reporting.¹⁹ The categories in this approach were developed inductively from the data.¹⁹

2.6 | Ethics

The ethics approval for this study was obtained from Darling Downs Health Human Research Ethics Committee for multisites (Ref: HREA/2020/QTDD/69958; Date: 10/11/2020). Subsequently, site-specific approvals were obtained from all the participating organisations.

3 | RESULTS

Although there were 250 respondents, 72 had missing data for the majority of questions (only background questions completed), leaving data from 178 respondents for inclusion in the analysis. Of these, 75 (42%) were allied health professionals, 70 (39%) were nurses or midwives and 33 (19%) were doctors. Data relating to current employment and CS of respondents are presented in Table 1. Most respondents had been in their role (64%), practising in their profession (86%) and receiving CS in their profession (53%), for over 2 years. At the time of survey completion, 56% of respondents were receiving CS. Health care workers from allied health (79%) were more likely to be receiving CS than medicine (52%) and, nursing and midwifery (34%; $p < 0.001$). Clinical supervision arrangements before the pandemic and at the time of survey completion are presented in Table 2. Irrespective of profession, CS type (i.e. one-to-one, peer group or other) and mode (i.e. face-to-face or telesupervision) before the pandemic and at the time of study were comparable (all tests $p > 0.05$).

Impacts of the COVID-19 pandemic on CS are presented in Table 3. Thirty-eight per cent of respondents agreed that their CS had been impacted by COVID-19 with March–May 2020 reported as the most disruptive (24%) and January 2021-time of study reported as the least disruptive (32%) periods for CS. Sixteen per cent of respondents had switched to a telesupervision model because of the pandemic, with 76% of respondents being satisfied with this format. Due to COVID-19, 15% of respondents had moved into a new role, 29% had taken on additional duties and 37% reported that their role had changed in some way. Eighteen per cent of respondents had a change in supervision arrangements but only 5% had a change in supervisor. Of those whose role had changed, 81% felt their current supervisor was still able to support them, 69% were still having their supervisory needs met and 76% were still meeting their organisational requirements. Sixty-two per cent of respondents agreed that their

TABLE 1 Current employment and clinical supervision of respondents.

Variable	Response	Frequency (N [%])
Time in current role	<6 months	20 (11.2)
	7–12 months	15 (8.4)
	1–2 years	30 (16.9)
	2–10 years	77 (43.3)
	>10 years	36 (20.2)
Time practising in the profession	<6 months	7 (3.9)
	7–12 months	3 (1.7)
	1–2 years	15 (8.4)
	2–10 years	53 (29.8)
	>10 years	100 (56.2)
Time receiving CS in the profession	<6 months	18 (10.1)
	7–12 months	6 (3.4)
	1–2 years	25 (14.0)
	2–10 years	50 (28.1)
	>10 years	44 (24.7)
	Do not receive CS	35 (19.7)
Currently receiving CS	Yes	100 (56.2)
	No	78 (43.8)
Time spent in current CS arrangement	<6 months	25 (14.0)
	7–12 months	20 (11.2)
	1–2 years	26 (14.6)
	2–10 years	35 (19.7)
	>10 years	9 (5.1)
	Do not receive CS	62 (34.8)

Abbreviation: CS, clinical supervision.

CS arrangement helped them to manage increased work pressures resulting from the pandemic.

While numerical data presented a snapshot of the disruptions, analysis of free-text comments (i.e. textual data) illuminate the type, nature and extent of the reported disruptions. Analysis of textual data resulted in the development of two categories: CS deteriorating and some CS functions more impacted than others.

3.1 | CS deteriorating

Several participants reported less-than-ideal CS arrangements even prior to the pandemic onset. A speech pathologist noted:

CS is ad hoc and reactive at the best of times. As a senior clinician, I am expected to just roll with the punches...

Echoing, this a nurse commented: (*I was*) lacking in CS prior to COVID, now I have nil.

Several participants across professions were unaware of their professional and organisational requirements for CS, with some also attributing little importance to CS:

I don't know what the organisational requirements are.
(dietician)

I am not sure and will need to look into my AHPRA training points/requirements.
(doctor)

CS is not a big priority during COVID times.
(mental health nurse)

Participants across professions explicitly noted issues that had impacted CS sessions, including increased workload, limited supervisor availability and travel restrictions:

CS was ineffective during the pandemic and did not improve as my supervisor's attention was drawn elsewhere.
(speech pathologist)

I only had supervision three times last year (i.e., 2020) due to the pandemic and travel restrictions...
(social worker)

Broad staff shortages as medical and nursing staff support the COVID initiative. Therefore, no coverage to support CS.
(nurse)

This is concerning as several staff noted a change in work role induced by the pandemic, as well as expansion of scope of work (both conditions that usually necessitate increased need for CS). A psychologist noted:

The COVID pandemic has resulted in supervision providers being busier and less available to provide supervision, plus there have been more complexities to the role that would benefit from supervision, that was thus even harder to achieve.

TABLE 2 Clinical supervision arrangements before the pandemic and at the time of survey completion.

Variable	Response	Medicine (N = 20)		Nursing & midwifery (N = 38)		Allied health (N = 64)	
		Prior (N, %)	Now (N, %)	Prior (N, %)	Now (N, %)	Prior (N, %)	Now (N, %)
Type of CS received prior to the COVID-19 pandemic and now	One-to-one CS	3 (15.0)	5 (29.4)	12 (31.6)	10 (41.7)	42 (65.6)	34 (72.3)
	Peer group supervision	1 (5.0)	1 (5.9)	7 (18.4)	1 (4.2)	2 (3.1)	5 (10.6)
	One-to-one and peer group CS	10 (50.0)	5 (29.4)	7 (18.4)	3 (12.5)	12 (18.8)	6 (12.8)
	Did not/do not receive CS	6 (30.0)	6 (35.3)	12 (31.6)	10 (41.7)	8 (12.5)	2 (4.3)

Variable	Response	Medicine (N = 23)		Nursing & midwifery (N = 47)		Allied health (N = 65)	
		Prior (N, %)	Now (N, %)	Prior (N, %)	Now (N, %)	Prior (N, %)	Now (N, %)
Mode of CS prior to the COVID-19 pandemic and now	Face-to-face	11 (47.8)	6 (35.3)	14 (29.8)	7 (29.2)	26 (40.0)	20 (42.6)
	Telesupervision	1 (4.3)	2 (11.8)	3 (6.4)	3 (12.5)	24 (36.9)	17 (36.2)
	Face-to-face and telesupervision	3 (13.0)	3 (17.6)	6 (12.8)	4 (16.7)	6 (9.2)	7 (14.9)
	Did not/do not receive CS	8 (34.8)	6 (35.3)	24 (51.1)	10 (41.7)	9 (13.8)	3 (6.4)

Note: Total numbers vary across questions due to missing data.

Abbreviation: CS, clinical supervision.

3.2 | Some CS functions more impacted than others

Findings indicate that formative and restorative functions of CS were more disrupted than the normative functions (of the Proctor's model of CS). This is concerning as it was a time of high stress and mental health concerns that effective supportive CS could have helped with. A senior nurse commented thus:

Increased workload due to number of people experiencing COVID anxiety and effects on their mental health.

This participant also noted that supervisors too need more support, as the mental health challenges they experienced affected their provision of CS:

My external supervisor experienced significant COVID anxiety, and this affected their ability to provide support to me professionally.

Changes in telesupervision arrangements, and lack of time, were attributed to reduced formative functions, which can be more detrimental to new graduates:

I am still meeting required hours, but the quality of supervision has been limited due to minimal face to face learning time.
(occupational therapist)

Lack of opportunity for feedback; supervisors uncontactable and less time for CS.
(new graduate nurse)

Some positive reports were noted across professions when supportive functions of CS were attended to, thereby enhancing supervisee wellbeing:

If I didn't have access to debriefing with a clinical supervisor, I would not be functioning at all at this time. The impact of COVID on the health workforce has been significant...The effects are only really starting to show now.
(senior nurse)

Helps me to identify strategies to deal with workplace stressors.
(occupational therapist)

TABLE 3 Impacts of the pandemic on clinical supervision.

Variable	Response	Frequency (N [%])
CS affected by COVID-19	Yes	33 (37.5)
	No	42 (47.7)
	Do not receive CS	13 (14.8)
Time periods most disruptive for the CS received	March–May 2020	58 (23.6)
	June–August 2020	28 (15.7)
	September–December 2020	29 (16.3)
	January-current	24 (13.5)
Time periods least disruptive for the CS received	March–May 2020	22 (12.4)
	June–August 2020	15 (8.4)
	September–December 2020	25 (14.0)
	January-current	56 (31.5)
Switch from face-to-face to telesupervision due to COVID-19 [^]	Yes	13 (15.5)
	No	54 (64.3)
	Do not receive CS	17 (20.2)
[^] Note: approximately <i>n</i> = 27 were identified as already doing telesupervision (switch unrelated to COVID-19)		
Satisfied with the telesupervision format	Satisfied	16 (42.1)
	Somewhat satisfied	13 (34.2)
	Not satisfied	9 (23.7)
Overall experience having switched to telesupervision	Excellent	6 (14.3)
	Good	19 (45.2)
	Average	12 (28.6)
	Poor	5 (11.9)
Telesupervision meeting expectations	Meets expectations	21 (50.0)
	Exceeds expectations	2 (4.8)
	Not meeting expectations	7 (16.7)
	Do not know	12 (28.6)
Confident using technology for skills/knowledge-based learning	Yes	26 (66.7)
	No	13 (33.3)
Confident in using the technology for debriefing/emotional support	Yes	26 (70.3)
	No	11 (29.7)
Moved into another work role due to COVID-19	Yes	9 (14.5)
	No	53 (85.5)

(Continues)

TABLE 3 (Continued)

Variable	Response	Frequency (N [%])
Additional duties in the same role due to COVID-19	Yes	18 (29.0)
	No	44 (71.0)
Role (scope, duties) changed following COVID-19	Yes	23 (37.1)
	No	26 (41.9)
	N/A (same role)	13 (21.0)
Changes to supervision arrangement (where scope/role changed)	Yes	11 (17.7)
	No	26 (41.9)
	N/A (did not change roles)	25 (40.3)
Change of supervisor due to COVID-19	Yes	3 (4.8)
	No	59 (95.2)
Supervisor has sufficient skills / knowledge to provide support (those who had a change in role but not supervisor)	Yes	17 (81.0)
	No	4 (19.0)
CS arrangements still meets supervisory needs (those who moved/changed roles)	Yes	18 (69.2)
	No	8 (30.8)
CS meeting organisational requirements (those who had changes in CS arrangements)	Yes	29 (76.3)
	No	9 (23.7)
CS meeting professional requirements (those who had changes in CS arrangements)	Yes	33 (53.2)
	No	5 (8.1)
	Do not know	24 (38.7)
CS assisted in coping with stress/increased work pressures from the pandemic	Yes	29 (61.7)
	No	18 (38.3)

Note: Total numbers vary across questions due to missing data and skip logic within the survey.

Abbreviation: CS, clinical supervision.

One participant, a psychiatrist, listed the strategies that their supervisor used, which enabled effective supportive supervision:

By listening to me, allowing to ventilate, validating my emotional state, allowing me to

look back with emotional calmness to arrive at different perspective and action plan.

4 | DISCUSSION

This study investigated the impact of the COVID-19 pandemic on CS practices of health care workers since the initial onset of the pandemic. As access to health care workers was a premium during that time, this study provides crucial information on the disruptions to CS experienced by health care workers at the point of care. Findings show that CS practices, across all included professions, were markedly disrupted, with nearly 40% of respondents agreeing that their CS had been impacted by COVID-19. It is clear in the literature that CS sessions have to occur regularly (at least monthly), with timely feedback, and need to be at least 45 to 60 minutes in duration, to be effective.^{9,11,20} Similarly, the supervisor being accessible and available is an important part of promoting a positive supervisory relationship, which is considered to be the most important factor in achieving effective and high-quality CS.^{9,21,22} Supervisees are said to be able to develop trust in supervisors who are deemed as experts in their own professions, which influences perceptions of credibility, and in turn promotes a positive supervisory relationship.^{11,20} In the current study, several participants reported disruption to these parameters, thus posing threats to the quality and effectiveness of CS. It is of interest that many noted that their CS was not effective or in place even prepandemic. Health care organisations need to consider the implications of this given the critical role of CS in ensuring sound clinical governance, on top of other staff, patient and organisational benefits.¹⁰

The COVID-19 pandemic has elevated the significant pressure the workforce was experiencing even before the pandemic.²³ A systematic review of 38 studies of health care workers reported alarming prevalence rates of pandemic-induced mental health problems for post-traumatic stress disorder (49%), anxiety (40%), depression (37%) and distress (37%).⁶ Findings in the current survey also echo the impact of the pandemic on participants' mental health and well-being. Interestingly, supportive supervision was not as prevalent as would be expected given the increased stress and well-being concerns experienced by supervisees. It is clear from the textual data that when supportive CS functions were effective (i.e. supervisor facilitated supervisee's coping through debriefing, validation, active listening and modelling), supervisees in this study reported better coping with the pandemic-induced stress and uncertainty at work. Benefits of a restorative (i.e. supportive) CS model have been demonstrated in the

UK through a pilot randomised controlled trial involving midwives and doctors, which showed a reduction in stress and burnout.²⁴ Benefits of a restorative CS model, plus competencies required by supervisors and supervisees to participate in this, have also been documented by Milne and Reiser.²⁵

Institutional commitment is necessary in making changes to work environments to ensure a supportive workplace culture.²⁶ Health care organisations are key to promoting a positive supervisory culture through the use of CS frameworks, policies, processes, tools and by ensuring staff are adequately trained and have protected time to engage in CS.^{10,11} Several participants in this study noted a lack of awareness of organisational and/or professional requirements of CS. It is timely for health care organisations to assess the current state of CS, and devise strategies to address identified gaps. Targeted training of staff (including in restorative CS), with follow-up support and monitoring, is required going forward. This not only ensures sound clinical governance for the organisation but also enhances staff mental health and well-being at work.¹³ Findings from this study can inform health care organisations to develop plans to future-proof CS practices of the workforce in unprecedented times into the future. Recommendations to do this have previously been proposed by the authors through six targeted strategies termed 'ENGAGE' strategies.¹³

4.1 | Strengths and limitations

This is the first known study to investigate the impact of the COVID-19 pandemic on CS of staff in regional and rural Australia. The study was inclusive of a broad range of professional groups. Availability of numerical and textual data provides more in-depth information on the disruptions caused. The study is limited by the use of a self-reported survey that was developed for this purpose, and as it was administered, online response rates are unable to be estimated. The survey was administered during a very busy period in health care settings, which could have impacted completion rates, and may have produced a biased sample of respondents. Missing data were also a challenge as many participants only partially completed the survey. Small cell counts could result in some results being somewhat unreliable. This study was conducted in Queensland, hence may not be generalisable to other contexts that had different COVID-19 experiences such as severity and lockdowns. Regardless, the study is strengthened by accessing a broad range of health care workers from several health care settings at a critical time. Thus, this provides an important first step in understanding the impact of the pandemic on staff CS practices.

5 | CONCLUSION

This study investigated the nature and extent of disruptions caused by the pandemic to health care workers' CS practices across several health care settings in Queensland. Study findings, combining numerical and textual data, show significant disruptions to several CS parameters, which could lead to ineffective or lower quality CS. Health care workers reported pandemic-induced stress and mental health challenges that were not always addressed by effective restorative CS practices. When restorative CS was well-facilitated by the supervisor, participants noted its positive impact on their mental health and well-being at work. This study provides information for health care organisations to review, restore and reboot CS practices at the point of care. Learnings from health care workers in this study during COVID-19 can inform future pandemic staff support plans or similar, so that CS practices can continue to be upheld during unprecedented times. Further studies can investigate the current state of CS using standardised measurement tools and qualitative methods.

AUTHOR CONTRIBUTIONS

Priya Martin: Conceptualization; formal analysis; supervision; project administration; methodology; investigation; funding acquisition; writing – original draft; writing – review and editing. **Geoff Argus:** Conceptualization; methodology; funding acquisition; writing – review and editing. **Jordan Fox:** Formal analysis; writing – original draft; writing – review and editing. **Tiana Gurney:** Conceptualization; methodology; formal analysis; writing – review and editing. **Matthew McGrail:** Formal analysis; writing – review and editing; writing – original draft. **Saravana Kumar:** Conceptualization; methodology; funding acquisition; writing – review and editing; supervision. **Srinivas Kondalsamy-Chennakesavan:** Conceptualization; methodology; supervision; funding acquisition; writing – review and editing.

ACKNOWLEDGEMENTS

We would like to acknowledge Dr Lucylynn Lizarondo, Ms Esther Tian and Ms Martelle Ford for their supportive involvement in the first author's postdoctoral fellowship which this study is a part of. Open access publishing facilitated by The University of Queensland, as part of the Wiley - The University of Queensland agreement via the Council of Australian University Librarians.

FUNDING INFORMATION

This manuscript is a part of Dr Priya Martin's postdoctoral fellowship, which was funded through an Advance Queensland Industry Research Fellowship

Grant by the Queensland Government Department of Tourism, Innovation and Sport; and co-funded by Darling Downs Health, Southern Queensland Rural Health, the University of Queensland Rural Clinical School and the University of South Australia. Grant number—AQIRF115-2020-CV.

CONFLICT OF INTEREST STATEMENT

The authors do not have any conflicts of interest to declare.

DATA AVAILABILITY STATEMENT


All data are protected by ethics. Reasonable requests to access de-identified data can be made to the first author and is subject to ethics approval.

ORCID

Priya Martin  <https://orcid.org/0000-0002-2092-6551>


Geoff Argus  <https://orcid.org/0000-0001-6849-1262>

Jordan Fox  <https://orcid.org/0000-0001-8367-5297>

Matthew McGrail  <https://orcid.org/0000-0002-6901-8845>

Saravana Kumar  <https://orcid.org/0000-0002-4003-4411>

Srinivas Kondalsamy-Chennakesavan  <https://orcid.org/0000-0002-1333-374X>

Srinivas Kondalsamy-Chennakesavan  <https://orcid.org/0000-0002-1333-374X>

TWITTER

Priya Martin  drprimart

REFERENCES

- Holton S, Wynter K, Trueman M, Bruce S, Sweeney S, Crowe S, et al. Immediate impact of the COVID-19 pandemic on the work and personal lives of Australian hospital clinical staff. *Aust Health Rev.* 2021;45(6):656–66. <https://doi.org/10.1071/AH21014>
- Tardif A, Gupta B, McNeely L, Feeney W. Impact of the COVID-19 pandemic on the health workforce in Canada. *Healthc Q.* 2022;25(1):17–20. <https://doi.org/10.12927/hcq.2022.26812>
- World Health Organisation (WHO) Switzerland. Available from: <https://www.who.int/teams/risk-communication/health-workers-and-administrators>
- Giorgi G, Lecca LI, Alessio F, Finstad GL, Bondanini G, Lulli LG, et al. COVID-19-related mental health effects in the workplace: a narrative review. *Int J Environ Res Public Health.* 2020;17(21):1–22. <https://doi.org/10.3390/ijerph17217857>
- Pappa S, Ntella V, Giannakas T, Giannakoulis VG, Papoutsis E, Katsaounou P. Prevalence of depression, anxiety, and insomnia among healthcare workers during the COVID-19 pandemic: a systematic review and meta-analysis. *Brain Behav Immun.* 2020;88:901–7. <https://doi.org/10.1016/j.bbi.2020.05.026>
- Saragih ID, Tonapa SI, Saragih IS, Advani S, Batubara SO, Suarilah I, et al. Global prevalence of mental health problems among healthcare workers during the Covid-19 pandemic: a systematic review and meta-analysis. *Int J Nurs Stud.* 2021;121:104002.

7. Spoorthy MS, Pratapa SK, Mahant S. Mental health problems faced by healthcare workers due to the COVID-19 pandemic—a review. *Asian J Psychiatr*. 2020;51:102119. <https://doi.org/10.1016/j.ajp.2020.102119>
8. Selvaskandan H, Nimmo A, Savino M, Afuwape S, Brand S, Graham-Brown M, et al. Burnout and long COVID among the UK nephrology workforce: results from a national survey investigating the impact of COVID-19 on working lives. *Clin Kidney J*. 2021;15(3):517–26. <https://doi.org/10.1093/ckj/sfab264>
9. Martin P, Copley J, Tyack Z. Twelve tips for effective clinical supervision based on a narrative literature review and expert opinion. *Med Teach*. 2014;36(3):201–7. <https://doi.org/10.3109/0142159X.2013.852166>
10. Martin P, Lizarondo L, Kumar S, Snowdon D. Impact of clinical supervision on healthcare organisational outcomes: a mixed methods systematic review. *PLoS One*. 2021;16(11):e0260156.
11. Rothwell C, Kehoe A, Farook SF, Illing J. Enablers and barriers to effective clinical supervision in the workplace: a rapid evidence review. *BMJ Open*. 2021;11(9):e052929.
12. Saab MM, Kilty C, Meehan E, Goodwin J, Connaire S, Buckley C, et al. Peer group clinical supervision: qualitative perspectives from nurse supervisees, managers, and supervisors. *Collegian (Royal College of Nursing, Australia)*. 2021;28(4):359–68. <https://doi.org/10.1016/j.colegn.2020.11.004>
13. Martin P, Kumar S, Tian E, Argus G, Kondalsamy-Chennakesavan S, Lizarondo L, et al. Rebooting effective clinical supervision practices to support healthcare workers through and following the COVID-19 pandemic. *International J Qual Health Care*. 2022;34(2):mzac030. <https://doi.org/10.1093/intqhc/mzac030>
14. Argus G, Walker C, Baratiny G, Cotter N, Fallon T. Perceptions, concerns and reported behaviours in response to the first wave of the coronavirus disease 2019 pandemic across metropolitan, regional, rural and remote Australian communities. *Aust J Rural Health*. 2022;30(3):352–62. <https://doi.org/10.1111/ajr.12842>
15. Pachana NA, Beattie E, Byrne GJ, Brodaty H. COVID-19 and psychogeriatrics: the view from Australia. *Int Psychogeriatr*. 2020;32(10):1135–41. <https://doi.org/10.1017/S1041610220000885>
16. Payne JL, Morgan A, Piquero AR. COVID-19 and social distancing measures in Queensland, Australia, are associated with short-term decreases in recorded violent crime. *J Exp Criminol*. 2022;18(1):89–113. <https://doi.org/10.1007/s11292-020-09441-y>
17. Gallagher HL, Doherty AZ, Obonyo M. International student experiences in Queensland during COVID-19. *Int Soc Work*. 2020;63(6):815–9. <https://doi.org/10.1177/0020872820949621>
18. Martin P, Tian E, Kumar S, Lizarondo L. A rapid review of the impact of COVID-19 on clinical supervision practices of healthcare workers and students in healthcare settings. *J Adv Nurs*. 2022;78(11):3531–9. <https://doi.org/10.1111/jan.15360>
19. Hsieh HF, Shannon SE. Three approaches to qualitative content analysis. *Qual Health Res*. 2005;15(9):1277–88. <https://doi.org/10.1177/1049732305276687>
20. Rothwell C, Kehoe A, Farook S, Illing J. *The characteristics of effective clinical and peer supervision in the workplace: a rapid evidence review*. 2019 Available from: <https://www.hcpc-uk.org/globalassets/resources/reports/research/effective-clinical-and-peer-supervision-report.pdf> [Accessed 25/10/2022]
21. Cliffe T, Beinart H, Cooper M. Development and validation of a short version of the supervisory relationship questionnaire. *Clin Psychol Psychother*. 2016;23(1):77–86. <https://doi.org/10.1002/cpp.1935>
22. Martin P, Kumar S, Lizarondo L, Tyack Z. Factors influencing the perceived quality of clinical supervision of occupational therapists in a large Australian state. *Aust Occup Ther J*. 2016;63(5):338–46. <https://doi.org/10.1111/1440-1630.12314>
23. Ruotsalainen JH, Verbeek JH, Mariné A, Serra C, Ruotsalainen JH. Preventing occupational stress in healthcare workers. *Cochrane Database Syst Rev*. 2015;2015(4):CD002892. <https://doi.org/10.1002/14651858>
24. Wallbank S. Effectiveness of individual clinical supervision for midwives and doctors in stress reduction: findings from a pilot study. *Evid-Based Midwifery*. 2010;8(2):65–71.
25. Milne D, Reiser RP. Supportive clinical supervision: enhancing wellbeing and reducing burnout through restorative leadership. UK: Pavilion publishing; 2020.
26. Boamah SA. The impact of transformational leadership on nurse faculty satisfaction and burnout during the COVID-19 pandemic: a moderated mediated analysis. *J Adv Nurs*. 2022;78:2815–26. <https://doi.org/10.1111/jan.15198>

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Martin P, Argus G, Fox J, Gurney T, McGrail M, Kumar S, et al. Nature and extent of disruptions to staff clinical supervision practices in health care settings due to COVID-19: A survey study. *Aust J Rural Health*. 2023;31:1008–1016. <https://doi.org/10.1111/ajr.13036>