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POSTER ABSTRACT

Clinical supervision in the bush: is it any different?

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Introduction: The complexities of rural and remote health professional practice in countries with a highly dispersed population are well-acknowledged. These professionals often feel isolated in their roles whilst dealing with resource constraints, geographical barriers and complex, generalist caseloads. Professional support mechanisms, such as clinical supervision (CS), are often paramount to recruitment and retention of the rural and remote health workforce. Although the value of CS in these contexts is realised, research into this is lacking. This presentation will draw upon a recent mixed methods study in this area, and other available literature, to outline the best practice in rural and remote CS.

Methods: Two recent systematic reviews and a recent Australian mixed methods study were examined. The systematic reviews investigated rural supervision experiences and telesupervision (CS undertaken using technology) respectively (Ducat & Kumar, 2015; Martin et al. 2017). The primary research study investigated the factors that contributed to high quality rural/remote CS using a standardised survey as well as explored supervisee experiences at the coal face through individual interviews (Martin, 2017). Information obtained was then organised into themes.

Results: Numerous factors were identified that contributed either positively or negatively to the quality of CS received in rural and remote areas including work setting, choice of supervisor, supervisee discipline and time in work role. Supervisees also shared their perspectives on the importance of context in CS, the unique characteristics of rural and remote CS, role of supervision on workforce retention, challenges with hands-on skills development activities and the need for accessing multiple forms of professional support. Ideal CS in rural and remote settings appears to be a regular, evolving and flexible arrangement, with face-to-face interaction and utilising more than one mode. Various enablers of and barriers to high quality CS in rural and remote settings were also identified.

Discussions: Research investigating the CS practices and experiences of rural and remote health professionals in Australia is lacking. Recent studies have shed light on the value and uniqueness of rural and remote CS. Information is now emerging on the factors that contribute to high quality CS as well as the associated enablers and barriers.

Conclusions: High quality CS is essential for clinical governance in health organisations. CS, when conducted efficiently, can lead to safer and higher quality health care. CS in rural and

remote areas is unique given the geographical barriers and resource constraints. Information is now emerging on what works and what doesn't in rural and remote CS. These findings are expected to be useful to health professionals, employing organisations and policy makers to enhance the rural and remote workforce recruitment and retention.

Lessons learned: Rural and remote CS has unique characteristics reflecting the complex nature of generalist roles. Some conditions need to be met to facilitate high quality CS.

Limitations/Future Research: Further studies with health professionals and bigger sample sizes are necessary to progress the evidence in this area.

Keywords: clinical supervision; rural and remote; professional support

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