The Acceptability and Experience of Online Clinical Supervision for Midwives By Helen Donovan

Thesis submitted in fulfilment of the requirements for the degree of

MASTERS OF MIDWIFERY (RESEARCH)

Under the Supervision of Professor Christine Catling and Professor Allison Cummins

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I, Helen Donovan, declare that this thesis is submitted in fulfilment of the requirements for the award of Master of Midwifery (Research), in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

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Glossary and Abbreviations

Facilitator/Supervisor	Used interchangeably in this study reflecting different terms used in the literature, referring to the person who facilitates the Clinical Supervision session
In-person	"In-person" has been chosen to refer to Clinical Supervision where all participants are in the same room, as opposed to "face-to-face", as online platforms can provide live visual of participants' faces. Some of the literature uses face-to-face to refer to in-person supervision.
Telesupervision	Supervision (Clinical or teaching) provided via distance medium – could involve telephone or online technology
Online	Use of online technology to enable live virtual meetings between two or more people with video cameras and screens
UNICEF	United Nations International Children's fund – a special programme of the United Nations. Its work is devoted to improving the health, nutrition, education and general welfare of children across the globe
UNFPA	United Nations Fund for Population Activities – works across the globe to ensure sexual and reproductive rights and choices for all, especially women and young people
ICM	International Confederation of Midwives – the global voice of midwives and promoting access to midwives for all women and gender diverse people
MGP	Midwifery Group Practice, a model of midwifery care where a woman receives care from one midwife (backed up by a small team) throughout her perinatal journey
ACM	Australian College of Midwives – professional body representing midwives across Australia
MNCLHD	Mid North Coast Local Health District
ISLHD	Illawarra Shoalhaven Local Health District

Abstract

Introduction

There is an abundance of evidence demonstrating that midwives are stressed in their roles, suffering from burnout, and considering leaving their profession. In addition, they are working within the context of a worldwide shortage of midwives. Clinical Supervision is a support strategy known to provide opportunities for midwives to pause, reflect, and reduce stress. The COVID-19 pandemic led to a pivot for healthcare and support being provided online, but little is known about the provision of online Clinical Supervision to midwives.

Aim

This research aimed to explore how acceptable online Clinical Supervision is for midwives and to gain information on their experience of the supervision provided as part of this study.

Methods

A mixed methods methodology was undertaken. Six months of online Clinical Supervision was provided to three groups of midwives (n = 15), recruited from two regional New South Wales local health districts. The quantitative data were collected via a survey distributed to all participants using the Research Electronic Data Capture (REDCap) platform. Eleven participants (73%) completed an online survey, comprising the Clinical Supervision Evaluation Questionnaire (CSEQ), and seven open ended questions that explored the experience and acceptability of online Clinical Supervision. These questions were aligned with the Theoretical Framework of Acceptability (TFA), which was developed to examine the acceptability of interventions for health staff. To further enhance these data, six one-to-one semi-structured interviews were conducted to further explore the findings of the TFA data within the surveys.

Results

The response to the monthly online Clinical Supervision was largely positive, with the CSEQ showing positive scores for all three subscales: purpose, process and impact. The qualitative data revealed five broad themes: (1) finding time and

space, (2) having flexibility, (3) valuing Clinical Supervision, (4) feeling safe, and (5) the online experience.

Conclusions

The study findings demonstrate the acceptability of online Clinical Supervision for midwives, who found the experience provided them with a safe space in which to reflect on work issues.

Implications for Practice

When setting up online Clinical Supervision, care should be taken to ensure that midwives have access to a safe, private space where they will not be interrupted or overheard. Protected time and managerial support are needed to ensure midwives are able to take time from their clinical duties. Access to the requisite equipment and internet access is essential. Adequate training for Clinical Supervisors should be provided, with additional training in online provision recommended.

Structure of Thesis

Introduction and Background

The opening chapter of this thesis explores the background of the current challenges within the midwifery workforce both internationally and within Australia. Burnout, moral distress and compassion fatigue are explained, and Clinical Supervision introduced in general terms. Online Clinical Supervision is explored with an explanation of how it might provide much needed support to midwives.

Chapter 1: Literature Review

In this section the current literature regarding online Clinical Supervision is examined, with an explanation of the search strategy employed to find the studies discussed. The included studies underwent quality appraisal and were synthesised and critiqued. A clear gap in knowledge was identified which led to the aim of this study.

Chapter 2: Methods

The methods section describes the methodology and design of the study. The rationale for the methods is documented, with the setting and recruitment strategy outlined. In addition, ethical considerations, data collection and analysis are described. Additionally, reflexivity is explored, within the context of this study.

Chapter 3: Findings

In this section the results of the study are examined. The findings from the CSEQ are outlined with explanations of the three subscales. The qualitative data from the online survey, with the additional data following thematic analysis of the semi-structured interviews are detailed. Additional data from the field notes are also included to give added meaning to the results.

Chapter 4: Discussion

This section examines the results of the study in the context of current literature, and explores and teases out meaning from the data, in relation to the

themes identified in the findings. The limitations and strengths of the study are outlined.

Chapter 5: Implications for Practice

This section includes recommendations identified from this study on how to set up online Clinical Supervision for clinicians, and the practicalities of ensuring engagement and positive outcomes of the strategy.

Chapter 6: Conclusions

Here the conclusions drawn from the findings and discussion are outlined, reviewing the main points gathered through the completion of the research.

Chapter 7: Reflections from a Clinical Supervisor

Here the author offers a personal reflection on conducting the study, having oscillated between two roles: the facilitator of the Clinical Supervision sessions and the research student.

Introduction

Midwives are recognised as health professionals who optimise the processes of birth, and as such are crucial to the health and well-being of childbearing women (Homer et al., 2014; Nove et al., 2021; Renfrew, 2021). They provide physical, psychological, social and cultural care to women throughout pregnancy, birth and during the initial postnatal period, and impact both short and long-term outcomes for both mothers and babies (ACM, 2024). The International Confederation of Midwives (ICM) defines a midwife as someone who has successfully completed a midwifery education programme which includes both the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education (ICM, 2024). In Australia the Australian College of Midwives (ACM) recognises midwives as health professionals who support women through the continuum of pregnancy, birth and the early postnatal period. The ACM recognises that with midwifery led care, women are more likely to have a normal birth of a healthy term baby, and to feel satisfied with their maternity care (ACM 2024). The ACM also states that midwifery is more than just a 'job', that for many it is a calling, or even a lifestyle (ACM 2024). Support during pregnancy and early parenting years have an undeniable effect on the health and well-being of mothers and families, and midwives have a vital role in this space, as well as mothers' future health and well-being and that of society as a whole (Edmonds et al., 2020; Renfrew, 2021). However, there is a body of literature that informs us that the work culture and wellbeing of midwives themselves are compromised (Carvajal et al., 2024; Homer, 2024; Matthews et al., 2022; Moran et al., 2023).

What led me to this study

I enrolled in a Bachelor of Midwifery in 2010, having dreamt of becoming a midwife for many years. I had long held a deep interest in women's health and wellbeing, and my work as a reflexologist had furthered my interest in pregnancy

and birth with many pregnant women coming to see me for treatment. I commenced my studies, and was delighted to be among like-minded, passionate individuals. I was very naïve, having enjoyed four healthy pregnancies and four beautiful life-affirming labours and births. The Bachelor of Midwifery course provided a rude wake-up call. The study load was demanding and challenging, requiring super-human time management skills and dedication to juggle full time study with a busy family schedule. Clinical Placement was both reaffirming and confronting, not forgetting the requirement of following ten women through their pregnancy, birth and early postnatal period each year, in addition to managing my busy household of six people. Nevertheless, I graduated and transitioned, within my first year of practice, to a much-wanted position in a Midwifery Group Practice. It was the dream. However, there were significant challenges within the workplace, with poor culture, and support for midwifery staff woefully absent.

I experienced and witnessed episodes of poor culture and mistreatment of both midwives and the women in our care over my student years and the following years of practice. This motivated me to mentor a number of students and early career midwives and support them through the challenges, helping them to make sense of their chosen profession and help them find some survival strategies. I also implemented projects designed to improve staff culture, but felt powerless in holding back the tide, and eventually came to the realisation that implementing change into an embedded culture is not easy on any level. I realised that if I wanted things to change, I needed to be part of that change at a deeper, wider level; I leapt at the opportunity to work in research, becoming involved in a midwifery workplace culture study, providing Clinical Supervision as part of a large cluster randomised controlled trial (RCT) (Catling et al., 2022). The Clinical Supervision training I received as part of that work was life changing. I was given the practical tools to support midwives in managing their stress and distress, and to help in culture change within their units.

The current study came about with the realisation that regional and rural midwives were not able to be a part of the RCT, as the intervention comprised in-person delivery of Clinical Supervision, and as such was out of the scope of the

study. One regional New South Wales (NSW) local health district had requested to be a part of the RCT, in which the Clinical Supervision was only provided in-person, and so that site was not able to be included due to distance. From that request, the idea for this study was conceived: was online Clinical Supervision an acceptable support for midwives?

Background

There is a shortage of midwives across the globe (Bar-Zeev et al., 2021; Nove et al., 2021). The State of the World's Midwifery report from May 2021 shows a deficit of approximately 900,000 midwives globally (Nove et al., 2021). While this alarming number mainly stems from not having enough educated midwives in low to middle income countries, there are also staff shortages in high income countries. Data from the UK showed that essentially (due to staff attrition) the equivalent of only one midwife out of 30 graduates enters the National Health Service in the United Kingdom (UK), which highlights the compounding problem of staff shortages there (Cull et al., 2020; Royal College of Midwives, 2019). This worldwide shortage of midwives leads to increased workloads, poor skill mixes on shifts and increased need for staff to work overtime. These aspects of midwifery work have had serious consequences on the staff themselves, which will be outlined below.

Midwifery work can be emotionally draining, and sometimes traumatic (Pezaro et al., 2016; Rost et al., 2024; Toohill et al., 2019). Being exposed to trauma over a sustained period of time can lead to psychological damage and increased stress, as indicated by a narrative review on work-related psychological distress in midwifery populations in the UK (Pezaro et al., 2016). Similar findings in the Australian midwifery population have also shown that locally, midwives are dissatisfied with their work conditions citing staffing shortages, a lack of support and lack of autonomy as contributing to high levels of work-related stress and burnout (Creedy et al., 2017). The Midwifery Futures report has surmised that the Australian midwifery workforce is in crisis, that there are not sufficient midwives and student midwives to meet the future needs of the country (Homer, 2024).

Australia has approximately 35,000 midwives, 25,500 of which hold a dual registration of both nursing and midwifery, and 4522 are single registration midwives (Department of Health, 2024). Studies have found that midwives are unhappy in their workplaces, with up to 47% of Australian midwives stating their intention to leave or considering leaving the profession (Harvie et al., 2019; Matthews et al., 2022; Pugh et al., 2013).These are not new findings, the issue was found over ten years ago with a Western Australian survey of midwives finding that almost half intended to leave their profession within five years (Pugh et al., 2013). A year later, an Australian government report anticipated a midwifery workforce shortage by 2030, with a predicted shortfall of nurses and midwives of more than 8000 (Health Workforce Australia, 2014). In Australia, the 'Future proofing the midwifery workforce in Victoria; a statewide cross-sectional study exploring health, well-being and sustainability' (FUCHSIA) study, provided evidence of widespread short staffing, poor culture and large numbers of midwives (approximately 60%) regularly consider leaving the profession. It also showed an increase in numbers of midwives considering leaving the profession over the previous ten years (Matthews et al., 2022). However, more contemporary evidence shows an adequate supply of midwives, but fewer hours being worked than ten years ago in Australia, with modelling showing that midwives work an average of 20 hours per week in this country (Callander et al., 2021; Homer, 2024). The Midwifery Futures report also highlights the lack of co-ordinated data collection across the Australian states and territories to model the future workforce, which is problematic when tasked with predicting future staffing requirements (Homer, 2024). Current data suggests a shortfall in midwives in non-metropolitan areas, which is particularly concerning for the provision of maternity services for women in regional and rural areas (Homer, 2024). It is likely that a large proportion of midwives are working part time due to family commitments, but there are also other reasons why midwives choose reduced hours. These include an awareness of managing or preventing burnout, because of physical injuries, or as they prepare for retirement (Cull et al., 2020; Homer, 2024). It is widely acknowledged that midwives need support, and creative solutions to stem the attrition of midwives are necessary (Catling et al., 2021; Homer, 2024).

There are a number of global factors that have exacerbated the staffing crisis in midwifery. The COVID-19 pandemic heightened stress for midwives around the world. In the UK the Royal College of Midwives found that over half the midwives surveyed (total number of respondents not available) reported that their mental health was worse as a result of the pandemic (Hunter et al., 2020). In addition, an Irish study from 2021 reported 90% of midwives surveyed (n=2642) were suffering from mental exhaustion and a quarter of them had planned to leave their jobs in the next 12 months (Irish Nurses and Midwives Organisation, 2021). Associated with these findings was the widespread phenomenon of midwifery burnout and moral distress, as explained below (Foster et al., 2023; Moran et al., 2023).

Australian literature confirms that more locally, the impact of the pandemic on the midwifery workforce was significant, with increased exhaustion, burnout and staff turnover (LoGiudice, 2024; Matthews et al., 2024). One study reported one midwife's reflection that the relentless pandemic had tried to stifle the inherent strength and resilience of midwives (LoGiudice, 2024). The high staff turnover saw an increase in the number of senior (more experienced) midwives resigning or retiring, resulting in a largely junior (less experienced) workforce remaining which has led to an unbalanced skill mix (Matthews et al., 2024). Currently over a third of midwives across Australia are aged 55 years and over, and thus eligible for retirement in the next ten years, further adding to the staffing crises (Homer, 2024). In addition to the attrition of midwives due to stress related to the pandemic and being of retirement age, many have left their discipline because they have suffered from burnout.

Burnout

Burnout is a recognised condition which is characterised by feelings of exhaustion, negativity and cynicism resulting from one's work and a reduction in professional effectiveness (WHO, 2019; Woo et al.(a), 2020). Burnout is a World Health Organization International Disease Classification recognised syndrome, which has been cited in the International Compendium of Diseases (ICD-11) since 2019 (Riethof & Bob, 2019). Symptoms include feelings of exhaustion, feeling

negative or cynical about one's job and reduced efficacy (Riethof, 2019). Often the signs of burnout are not recognised until the symptoms have become severe (Ledingham et al., 2019).

Many health professions experience high levels of burnout, such as nursing, allied health, and medical staff (Riethof, 2019). A plethora of studies demonstrate midwives have high levels of burnout and show that midwives are not only feeling burnt out but also, stressed, overworked and unsupported (Catling & Rossiter, 2020; Catling et al., 2017; Creedy et al., 2017; Harvie et al., 2019). One large international study undertaken in twelve countries, The Work Health and Emotional Lives of Midwives (WHELM) report, showed that up to 75% of the midwives surveyed were considering leaving their profession, largely due to work-related burnout (Cull et al., 2020). The study also provided more nuance regarding midwifery burnout by showing that of all the midwives in the WHELM study who were working in the UK, 83% had work-related burnout, but only 15% had client-related burnout (Cull et al., 2020). This means that midwives largely did not suffer burnout from working alongside women and their families (clients) but from elements of their profession. These elements were determined to be working in an under resourced maternity system with widespread staff shortages (Hunter et al., 2019). A recent Swedish study comparing levels of burnout in midwives across the years 2012 – 2022 showed an alarming increase, with early career midwives and midwives not working in continuity models showing the highest increases in burnout (Hildingsson et al., 2024). It is well documented that midwives have high levels of burnout, stress, and possess feelings of being overworked and unsupported in their role (Catling & Rossiter, 2020; Catling et al., 2017; Creedy et al., 2017; Harvie et al., 2019; Moran et al., 2023).

The ubiquity of perceived midwifery burnout is particularly alarming given the worldwide shortage of midwives. Research has found clear links between burnout and midwives' desire to leave their profession (Matthews et al., 2022; Matthews et al., 2024; Moran et al., 2023). Another clear problem with the workforce is that midwives also suffer from moral distress.

Moral Distress

Alongside burnout is the emerging awareness of moral distress. Moral distress was coined in the 1980s to describe the psychological distress caused by being in a situation where one is prevented from acting on what one knows to be right (Rost et al., 2024). This is described as a fundamental undermining of moral integrity in one's professional practice (Foster et al., 2023). Midwives report feeling demoralised within current public maternity care systems, lacking resources and contending with a rising intervention rate, and having to compromise the quality of care they provide to women and their families (Foster et al., 2023). Low staffing levels have been shown to reduce breastfeeding rates and increase neonatal admission to special care nurseries (Dani et al., 2020). Midwifery work is ethically complex, serving both the woman's needs and those of her baby (Rost et al., 2024). This becomes more complex when considering organisational issues such as negative or unsupportive working cultures, and hierarchical systems within health, and these contribute to midwives experiencing moral distress (Rost et al., 2024). High levels of moral distress are also fuelled by increased pregnancy terminations, increased fetal assessments and diagnoses, and a challenging contemporary birth culture encouraging defensive practice (Rost et al., 2024). Defensive midwifery practice can include increased reliance on interventions and pharmacological pain relief, and earlier referral to obstetric led care (Daemers et al., 2017).

Moral distress can be understood on a continuum (Foster et al., 2023). This begins at the lower end with moral frustration, where midwives feel low levels of discomfort and experience short-term negative outcomes. Following this, clinicians can move through to feeling moral distress and then experience moral injury at the higher end. Moral injury presents as having a prolonged severe psychological impact and has been likened to post traumatic stress disorder (PTSD). Moral distress is considered to be an umbrella term which represents moderate psychological harm in response to being exposed to moral compromise (Foster et al., 2023). Another symptom of exhaustion and moral distress can be compassion fatigue.

Compassion Fatigue

Compassion is recognised as an emotional response to another being's pain or suffering and eliciting a strong wish to provide assistance or support (Mayra et al., 2023). Compassion is highly valued by both midwives, their colleagues and the women they care for, but can be eroded by workforce shortages, exposure to vicarious trauma, toxic work cultures and the increasing medicalisation of birth (Mayra et al., 2023). Compassion fatigue contributes to both poorer experiences and outcomes for women and has implications for staff satisfaction and retention (Marshman et al., 2022). Compassion fatigue often presents in terms of a lack of empathy, support or compassion for women, colleagues and oneself (Mayra et al., 2023). The COVID-19 pandemic saw an increase in incidence of compassion fatigue amongst midwives (Aydin Dogan et al., 2023). Additionally, compassion fatigue has been noted in student midwives, with concern for their overall wellbeing, and self-care (Beaumont et al., 2016).

In summary, it is clear that midwifery work is emotionally draining and sometimes traumatic (Pezaro et al., 2016). Being exposed to trauma over a sustained period can lead to psychological damage and increased stress. Without adequate institutional support, this can impact the well-being of the midwifery workforce (Pezaro et al., 2016). A recent study conducted among midwives in the UK found that up to 28% of midwives met the criteria for problematic substance abuse, using alcohol and other drugs to manage work related stress, poor workplace culture and burnout (Pezaro et al., 2022). Midwives' reliance on alcohol and other drugs has been shown to increase the risk of harm to mothers and babies (Pezaro et al., 2022). Burnout, moral distress and compassion fatigue as well as staff shortages are strong contributing factors behind the current midwifery shortage within Australia and around the globe.

Midwifery Workforce

As stated earlier, Australian research shows that there are not enough midwives or midwifery students to meet our future needs, and that almost a half

(47%) of surveyed midwives were considering leaving the profession (Homer, 2024; Matthews et al., 2022). Having a lack of staff in the workplace leads to greater workloads for the remaining midwives, and an inability to provide high quality care (Foster et al., 2021; Irish Nurses and Midwives Organisation, 2021). Poor staffing is both caused by and contributes to a range of factors as seen in Figure 1 below. Continued short staffing, among the many causes, leads to increased stress and workload for the remaining staff, leading to increased exhaustion, burnout and moral distress, and ultimately more midwives leaving the profession (Carvajal et al., 2024; Rost et al., 2024). It should be noted that the progression through compassion fatigue, moral distress and burnout is not linear and can happen independently or concurrently. Midwifery students are also at risk of these phenomena.
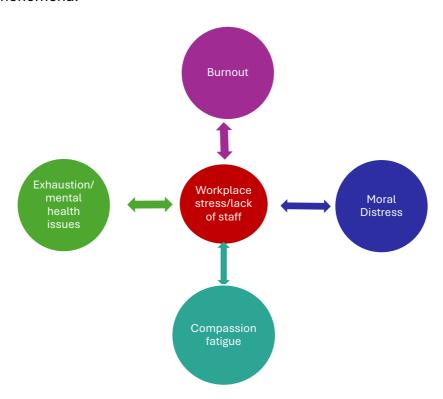
Figure 1: Workplace stress factors

Midwifery Students

Midwifery students are at risk of leaving their degrees, which exacerbates the shortfalls in the pipeline of new graduates joining the profession. A recent study from the UK shows increasing attrition from student midwifery programs,

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currently sitting at approximately 13.8% (Moran et al., 2024). In Australia there are no similar data, however more than half of surveyed midwifery students in the Midwifery Futures report (2024) had considered withdrawing from their studies, and 11% of newly qualified midwives were not working in midwifery (Homer, 2024). Another recent study found that up to two thirds of midwifery students expressed a preference to work part time when they enter the workforce (Evans et al., 2020). In order to ensure adequate numbers of midwives for the future, it has been recommended that midwifery student numbers be increased by up to 20% (Homer, 2024), but it bears consideration that each additional midwifery student requires clinical midwives to mentor them in the workplace in order for them to complete their degree, thus adding to the overall midwifery workload. As well as midwifery students, early career midwives are also at risk of leaving their profession.

Early Career Midwives

One of the studies from the WHELM program showed that early career midwives in the UK, meaning those in their first five years of practice, are far more likely to leave the profession than the older, more experienced cohort (Cull et al., 2020). More recent Australian studies have similar findings, citing a range of contributing factors including qualification burnout – residual emotional, physical and economic depletion from completing university studies; ideological discord, and a chronic lack of support within the health system (Donnelly et al., 2024; Harvie et al., 2019; Parry et al., 2024). This is all amplified when combined with short staffing and attrition of more experienced midwives, leaving an unsupported junior workforce with challenging workloads (Donnelly et al., 2024).

In order to mitigate the issues relating to the staff shortages and burnout rates in midwifery, healthcare organisations have recognised that effective strategies to stem attrition are necessary. This study focused on one such strategy: online Clinical Supervision for midwives.

Clinical Supervision

One solution to the endemic problem of stress and burnout within the midwifery profession and workforce attrition is the provision of Clinical Supervision for midwives. Clinical Supervision provides protected time for health professionals to engage in facilitated deep reflective practice (Harvey et al., 2020). Reflective practice is described by the NSW Clinical Excellence Commission (CEC) as engaging in a process of clear thinking with honesty including deep and critical reflection about any aspect of professional practice (CEC, 2024). The CEC recognises that reflective practice is crucial to both safety and quality, and for processing the very challenging demands of healthcare provision (Harvey et al., 2020). In the UK, the regulation for mandatory supervision for midwives was ended in 2017 (Pollock et al., 2017). Mandatory (statutory) supervision referred to the supervision of a group of junior midwives by a senior colleague, providing opportunity for advice on practise issues when needed. Like Clinical Supervision, statutory supervision had a different meaning to supervision of clinical skills (Pollock et al., 2017). The cancelling of this mandated support left midwives without professional support for their work, which could often include psychological interventions, particularly with specialist midwives providing care to vulnerable populations (Archibald et al., 2025).

Clinical Supervision traditionally has three components: formative, or educational; normative, or administrative which focuses on organisational and policy implementation. The third component is restorative which focuses on professional well-being with facilitated and supported reflection (Winstanley & White, 2003). The Australian Clinical Supervision Association (ACSA) recognises that Clinical Supervision lacks a clear definition, and supports the concept that it is a structured, professional relationship built on trust and respect, where the supervisee is supported to reflect on their practice, to explore ethical issues and is assisted in developing critical thinking skills (ACSA, 2021).

There are some health disciplines that have embraced Clinical Supervision, having benefitted from this support strategy for many years. These include social work, mental health nursing and psychology; the latter being the profession where

Clinical Supervision originated (White, 2017). Psychologists also go one step further and have to attend at least 10 hours of supervision annually to maintain their registration (Psychology Board AHPRA, 2015). It is also a recognised and recommended support strategy for nurses and midwives, formalised by the Australian College of Midwives (ACM), the Australian College of Nurses (ACN) and the Australian College of Mental Health Nurses (ACMHN). These professional organisations issued a joint statement recommending the incorporation of Clinical Supervision into their workforces (ACM ACN and ACMHN, 2024). This statement recommends Clinical Supervision for all nurses and midwives regardless of their role, their clinical area of employment or how long they have been registered (Harvey et al., 2020). Further, the New South Wales (NSW) Ministry of Health recommends Clinical Supervision for all health professionals to facilitate reflection on their practice and thus improve quality of care. This has been reinforced through NSW Health in its mandatory education online learning portal which identifies Clinical Supervision as professional development (Health Education and Training Institute, 2013).

Despite government and professional organisational endorsement of Clinical Supervision, there are no studies that record how many midwives actually access Clinical Supervision on a regular basis in Australia. In addition, little is known about how many clinicians have been trained as facilitators of Clinical Supervision. Some health services in NSW have provided Clinical Supervision training for some nurses and midwives (Health Education and Training Institute, 2013). However, evidence shows that despite successfully completing this training, there are many barriers to being able to utilise their newfound skills and provide Clinical Supervision to their midwifery colleagues (Love et al., 2017). Many midwives are unable to access Clinical Supervision due to a variety of factors, including an inability to attend as they are often not released during work time, and there is a lack of access to suitably trained supervisors, especially in regional and remote areas (Martin et al., 2018). Another barrier can be the common misconceptions which persist around what Clinical Supervision is, and who it is for. Many midwives and nurses are confused by the term, often interpreting it to

refer to supervision of clinical skills, or more educational, and therefore more suited to students and junior staff members (Doody et al., 2024; Love et al., 2017).

There are many reported benefits for healthcare staff who access Clinical Supervision. Clinical Supervision provision for midwives both in Australia and overseas is associated with a positive impact on participants' personal and professional lives (Archibald, 2025; Love et al., 2017; Pollock et al., 2017). The mixed methods study of 225 midwives by Love et al (2017) found a positive relationship between Clinical Supervision and midwives' work culture, and that those engaging in regular supervision felt more positive about their role and their workplace. The same study reported midwives felt Clinical Supervision enhanced their professional confidence, they felt supported and valued, as well as benefitting from improved teamwork and communication at work (Love et al., 2017). Participants reported that Clinical Supervision provided a safe space to reflect and process their experiences, however, unlike the study in this thesis, this was based on in-person Clinical Supervision, not online. Only one study has used a randomised controlled trial methodology to determine the efficacy of supervision for midwives. This study of midwives and obstetricians published over 14 years ago showed a positive relationship between being provided six sessions of Clinical Supervision and participants' perceptions of work-related stress (Wallbank, 2010). The intervention in the study was delivered in-person, therefore it is unclear whether an online Clinical Supervision delivery would have the same effect.

There is little evidence available that reports midwives' benefitting from Clinical Supervision apart from Love et al. (2017), described above, and more recently Archibald et al (2025). This was also acknowledged by Pollock et al. (2017) and noted that this was the case despite widespread recognition that it was considered to be an important part of good professional practice (Pollock et al., 2017). What is also unknown in the literature is whether midwives would benefit from Clinical Supervision delivered online.

Traditionally, Clinical Supervision is provided via in-person attendance, however with the onset of the COVID-19 pandemic and the rapid change to

delivering many services online, many in-person Clinical Supervision sessions were cancelled. The impact on this provision of Clinical Supervision was discussed in a recent paper that highlighted the impact of the sudden change from in-person interactions to the virtual format, including training and support for healthcare workers (Soheilian et al., 2023). Clinical Supervision may have pivoted to online delivery for many during the pandemic, however this method of delivery for midwives has not been examined.

Online provision of Clinical Supervision

Being online has become a routine part of the work and leisure landscape in recent years, and particularly since the start of the COVID-19 pandemic. Due to widespread lockdown periods and the need for people to work effectively from home and socially distance, many previous in-person activities have moved to an online platform such as Skype ™, Microsoft Teams™ or Zoom™ (Chaisty & Cunningham, 2021; Perle & Zheng, 2024; Ratcliffe & Kaluzeviciute-Moreton, 2024). This change was rapid and many health-related consultations, such as those for pregnant women, were introduced without evidence for their safety and efficacy. Those health professionals engaging in regular Clinical Supervision may have also transferred to an online platform.

Recent literature reviews have examined the online provision of Clinical Supervision to healthcare workers, but none of the included studies have involved midwives (Hildebrand et al., 2023; Martin et al., 2018; Martin et al., 2022; Ratcliffe & Kaluzeviciute-Moreton, 2024; Watters & Northey Jr, 2020; Woo et al., 2020). One systematic review of online Clinical Supervision to a range of health professionals was conducted by Martin et al., (2018). These authors included 11 papers in their review, and found Clinical Supervision was perceived to be more effective if the participants had previously established a good working relationship prior to going to an online space. These authors used the term telesupervision, by which they meant Clinical Supervision conducted using technology such as telephone, email or online (Martin et al., 2018), with email supervision comprising questions and answers sent over time. The term telesupervision was defined by Watters et al. (2020) as an interaction between supervisor and supervisee who are in different

locations and is conducted in real time (Watters & Northey Jr, 2020). These studies identified and discussed eight themes that contributed to high-quality telesupervision: supervisee characteristics, supervision facilitator characteristics, supervisory relationship, communication strategies, prior in-person supervisory relationship, environmental factors and finally technological issues. The core supervisee competencies that were recognised as necessary were characteristics such as the ability to process clinical issues systematically, to recognise when Clinical Supervision was needed, and to pursue professional development (Martin et al., 2018; Watters & Northey Jr, 2020). For supervisors there were also recognised competencies, included technological competence, boundary setting, communication skills and competence in the clinical context (Watters & Northey Jr, 2020).

Models of Clinical Supervision were examined by Hildebrand et al., (2023). These authors examined a number of different models encompassing the three components of Proctor's model (normative, formative and restorative; Proctor, 1997), and proposed that for remote area nurses, a hybrid model be further explored and measured, with in-person education on a short-term basis, and longer-term group and on-demand supervision provided online (Hildebrand et al., 2023). Another review by Ratcliffe et al. (2024) found very little evidence of any difference in quality between online and in-person Clinical Supervision in counselling and psychotherapy practitioners. They noted that one paper in their review argued that any difference in efficacy found was likely to be attributable to supervisor/supervisee variables rather than the method of delivery (Jordan & Shearer, 2019). Another aspect of online Clinical Supervision was noticed by Watters et al. (2020) - that participants may pause longer than in-person supervisees, which in a one-to-one setting is not problematic, but in a group setting can allow other group members to take over and interrupt the flow of conversation. Similarly, it was noted that there was more potential for multi-tasking, i.e. checking emails, reading documents etc. with online Clinical Supervision (Ratcliffe & Kaluzeviciute-Moreton, 2024).

This study set out to explore the acceptability of online Clinical Supervision for Australian midwives and adds to the growing body of evidence for this vital support strategy. The next chapter will provide an overview of the current literature concerning Clinical Supervision, with a focus on online provision.

Chapter One: Literature review

Introduction

Clinical Supervision is a structured professional relationship that facilitates deep reflective practice (ACSA, 2021). It is widely considered to be an integral element of professional practice for health disciplines, providing midwives and other health professionals with an opportunity to receive support, develop their practice and promote their emotional wellbeing (Love et al., 2017; White, 2017). It can also enhance feelings of being supported by the organisation and lead to the provision of high-quality care (Hildebrand et al., 2023). Transitioning to the online provision of Clinical Supervision would seem to be an obvious solution both during the COVID-19 pandemic crisis, that required restrictions on in-person interactions, and in the longer term for staff working in regional and remote health.

Rural and remote areas of Australia have particular difficulties regarding the provision of Clinical Supervision. These include limited suitable and trained clinical supervisors, as well as competing chronically high clinical workloads, inadequate staffing issues and large geographical distances which contribute to the issue of finding time for clinicians to access Clinical Supervision (Hildebrand et al., 2023; Snowdon et al., 2020; Gardner et al., 2021). Unlike in-person Clinical Supervision, it is unclear whether the online provision of this support strategy is effective or acceptable to clinicians. Therefore, the purpose of this literature review was to examine the available research on the acceptability of online provision of Clinical Supervision for midwives.

Search strategy

This literature review comprised an initial search, the main search and an update in November 2024. All were conducted using CINAHL (Cumulative Index to

Nursing and Allied Health Literature), Medline, Embase, and MIDIRS (Midwives Information and Resource Service) databases.

The initial search was undertaken on March 1st, 2021, using the keywords "online", "clinical supervision" and "midwives" which returned zero results. Boolean operators, truncation and phrasing were utilised in the manner appropriate to the database being searched. In the relevant databases, these keywords were mapped to Medical Subject Headings (MeSH), and the search terms were then broadened to include the words: teleconferencing, Skype, Zoom, Webex, Pexip, virtual, distance and remote as well as online, with keywords identified using the Population, Intervention, Comparison and Outcome (PICO) framework. Using this framework assists in clearly placing the research question into relevant search terms for a literature review (Hildebrand et al., 2023). Following the initial search that produced no results related to midwifery alone, additional terms were included to capture studies of online Clinical Supervision with other health disciplines and related terms that are used for this support strategy. Therefore, the literature review question was "what is the acceptability of online provision of Clinical Supervision to healthcare professionals?". See Table 1 for the combinations of keywords used in this review.

Table 1: Search Terms and Combinations

A Combined with OR Clinical Supervision	B Combined with OR online	C Combined with OR Midwifery
Reflective Supervision	Online	Midwi*
Reflective Practice	Skype	Nurs*
Practice Development	Zoom	Social work*
Telesupervision	Teleconferencing	Allied health
Peer supervision	Webex	Psycholog*
	virtual	Occupational therap*
	MS teams	Physiotherap*

	technology	Podiatr*

Complicating the search strategy was the lack of consistent terminology for Clinical Supervision and online at either institutional, state, national or international levels. Pre-reading some of the literature helped identify the various terms so they could be added to the keyword search (see Table 1). These concept terms were entered into the selected databases and from the searches an addition of six records were found through other sources. A total of 1133 potentially relevant studies were identified. This reduced to 782 after removal of duplicates. Papers published before 2010 were excluded as the access to and use of online video technology before that time was considered to be less widespread. Further application of filters removed conference papers, letters and dissertations, and included only papers written in English and those where "Clinical Supervision" appeared as a phrase within the text. From the remaining papers, further exclusions were papers with any titles or abstracts that included Clinical Supervision that implied supervision of clinical skills or teaching, or training of clinical skills. Systematic reviews, literature reviews and rapid reviews were also excluded, and primary research studies were prioritised. The remaining papers were included in the final synthesis (n = 7). See the Preferred Reporting Items for Systematic Reviews (PRISMA) flowchart, Figure 2 (Page et al., 2021).

The search strategy was discussed with the supervisory team and two librarians. Due to the small number of relevant articles found, the search strategy was further discussed with another librarian and repeated, with the inclusion of Google Scholar. No further papers were found. The broader search was replicated and repeated on 8th November 2024, with the additional literature included in this chapter, and integrated into the PRISMA flowchart (see Figure 2 below).

The included articles that utilised a qualitative methodology were then evaluated using the Critical Appraisal Skills Programme (CASP) qualitative studies tool to assess the quality of the research undertaken. This is a validated tool for

this purpose (Long et al., 2020). The CASP results are included in Table 2, and as a result of this evaluation no papers were excluded from this study.

PRISMA Flow Diagram
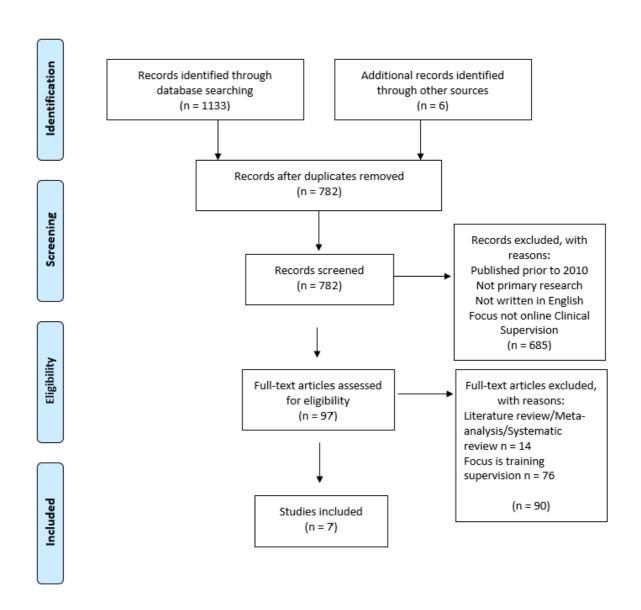
Figure 2: PRISMA Flow chart of included studies

Findings

All of the seven papers included in the review related to Clinical Supervision as a structured professional relationship that facilitates deep reflective practice (Bruce et al., 2018; Chaisty & Cunningham, 2021; Connell, 2023; Howard & Peirson, 2024; Soheilian et al., 2023; Tarlow et al., 2020; Williams et al., 2022). None of the papers studied midwives as recipients of Clinical Supervision. There was a range of different health disciplines studied in the papers reviewed: psychologists and counsellors (Chaisty & Cunningham, 2021; Soheilian et al., 2023; Tarlow et al., 2020), early childhood nurses (Bruce et al, 2018), student mental health nurses (Howard & Peirson, 2024), and social workers (Connell, 2023; Williams et al., 2022), see Table 2.

Of the seven included studies there were various methodologies used. These included one multiple baseline single-case study (Tarlow et al., 2020), three mixed methods studies (Chaisty & Cunningham, 2021; Connell, 2023; Soheilian et al., 2023), and three qualitative studies (Bruce et al., 2018; Howard & Peirson, 2024; Williams et al., 2022). All papers were largely positive in their assessment of the online space for the provision of Clinical Supervision to health workers. Although none of the studies addressed online Clinical Supervision within the midwifery profession, the nature of Clinical Supervision provision to other health professions (the online delivery) is significant to this study.

All seven studies involved the provision of Clinical Supervision via an online platform such as Skype™, Zoom ™ or Microsoft Teams. For the majority of the studies this was commenced following a period of in-person Clinical Supervision which then pivoted online either as a result of or prior to the Covid-19 pandemic (Connell, 2023; Soheilian et al., 2023; Tarlow et al., 2020 Williams et al., 2022). Three of the studies involved online provision only (Howard & Peirson, 2024; Bruce et al., 2018; Chaisty & Cunningham, 2021).

Table 2: Summary of papers reviewed

Authors, Year, Country	Title	Methodology and methods	Discipline	CASP	Summary of Findings
Bruce, Byrne and Kemp, 2018, South Korea (Australian researcher)	Using Skype™ to support remote clinical supervision for Health Professionals: Delivering a sustained Maternal Early Childhood Programme: A Phenomenographical Study	A phenomenographical study examining the supervisor's experience of facilitating online supervision. Clinical Supervision delivered online via Skype™ on a monthly basis to eight participants.	Early Childhood nurses and social care practitioners	Med	The online medium was found to enhance verbal communication, engage both sight and sound, so included sensitivity to visual cues.
Chaisty and Cunningham, 2021, UK	An Exploration of Staff Member's Experiences of Receiving Clinical Supervision using Virtual Platforms, during the Covid-19 Pandemic	A mixed methods study exploring 12 participants' experience of online supervision, utilising an online survey with a validated tool to assess the Clinical Supervision and open-ended questions.	Clinical Psychologists	Med	Quantitative date showed strong supervisory relationships, and the qualitative data showed positive response to the online experience. They noted increased flexibility in scheduling, an increased focus, and less distraction during sessions.

Authors, Year, Country	Title	Methodology and methods	Discipline	CASP	Summary of Findings
Connell, 2023, UK	Putting the 'Virtual' into Supervision during the COVID-19 Pandemic and Beyond	A mixed methods study assessing the impact of the change from face-to-face to online Clinical Supervision between March 2020 and January 2021. Online anonymous survey and semi-structured interviews with 22 completed surveys and eight interviewees	Child and Family Social Workers	Med	Quantitative data showed a positive response overall, with some participants finding some element of reflection lost online. Qualitative data found the online provision provided space for reflection with some issues with connectivity and/or technology.
Howard and Peirson, 2024, UK	Online Group Supervision as Pedagogy: A Qualitative Inquiry of Student Mental Health Nurses' Discourses and Participation	Qualitative Inquiry utilising focus groups to gain insights into the participants views, understandings and experiences of online group Clinical Supervision utilising Microsoft Teams™	Student Mental Health Nurses	Med	There was a positive response and a valuing of Clinical Supervision. They identified a need to improve confidence and trust in online participation, and a need for increased familiarity with the online setting.

Authors, Year, Country	Title	Methodology and methods	Discipline	CASP	Summary of Findings
Soheilian, O'Shaunessy, Lehmann and Rivero, 2023, USA	Examining the Impact of COVID-19 on Supervisees' Experiences of Clinical Supervision	A mixed methods study examining 324 participants' experience of Clinical Supervision pivoting to online delivery during Covid 19 pandemic	Psychologists	High	Quantitative data showed a moderately positive response from the participants towards online Clinical Supervision. The qualitative data showed that the participants were challenged by technology, communication and organisation, and found increased flexibility, convenience and time/money saving by attending supervision online.
Tarlow, McCord, Nelson and Bernhard, 2020, USA	Comparing In-Person Supervision and Telesupervision: A Multiple Baseline Single-Case Study	A pre-COVID-19 mixed methods study exploring 3 participants undergoing a rapid shift from face-to-face to online supervision.	Psychotherapists	Med	Quantitative data showed equivalent outcomes for online and in-person supervision after the shift. Qualitative data found four themes: differences between modalities, characteristics of an effective supervisor, role of technology, and personal preference.
Williams, Ruch and	Creating the Conditions for Collective Curiosity	Qualitative thematic analysis based on feedback from	Social Workers	Med	Qualitative data analysis revealed three key themes largely focused on the

Jennings, 2022, UK	and Containment: Insights from Developing and Delivering Reflective Groups with Social Work Supervisors	small group reflective practice over ten years - started in-person but pivoted to online during the COVID-19 pandemic.			experience of the Clinical Supervision. In regard to the online provision, the feedback was consistent with the in-person participants. They found the facilitator role more challenged in the online space.

The frequency of online provision of Clinical Supervision as reported in the included studies, ranged from weekly (Chaisty & Cunningham, 2021) through to monthly (Bruce et al., 2018; Chaisty & Cunningham, 2021), although not all papers included information regarding the frequency of the sessions. Some of the papers examined the provision of group Clinical Supervision (Bruce et al., 2018; Howard & Peirson, 2024; Williams et al., 2022), for others the focus was individual Clinical Supervision (Chaisty & Cunningham, 2021; Tarlow et al., 2020). Some studies did not specify whether the Clinical Supervision had been provided to a group or individually. In two of the papers, the researcher was also the facilitator of the Clinical Supervision (Bruce et al., 2018; Tarlow et al., 2020), which will be discussed below.

The main themes identified in the literature were: the benefits of being online for Clinical Supervision, the challenges of online for Clinical Supervision, non-verbal cues, access to technology to facilitate online Clinical Supervision, and how facilitator skills affect online Clinical Supervision. These will be critiqued and synthesised below.

Benefits of being online for Clinical Supervision

Before the COVID-19 pandemic, online Clinical Supervision was available but not often the chosen mode of delivery by supervisors or supervisees as it was seen as lesser quality compared with the more traditional in-person delivery of Clinical Supervision (Tarlow et al., 2020). Tarlow et al. (2020) cite issues with client confidentiality and unexpected technical problems as contributing to both supervisors and supervisees not choosing online delivery. However, as outlined in the previous chapter, since the onset of the COVID-19 pandemic, there has been an increased interest in the use of technology for Clinical Supervision. Soheilian et al. (2023) acknowledged that the lack of research in online Clinical Supervision is largely due to the preference for in-person delivery prior to the COVID-19 pandemic. In-person Clinical Supervision was previously proposed as superior to online Clinical Supervision, whereas now there is increased connectivity and

confidence in technology, and this has opened up the world of online Clinical Supervision (Soheilian et al., 2023).

The growth in use of technology for Clinical Supervision may have been brought about by the necessity to use this mode of delivery, rather than the explicit desire to do so. Social distancing recommendations and travel restrictions brought about by public health orders have meant that being online became vital and more widely acceptable for professional and social meetings. This has had some positive benefits for some low-income and middle-income countries with the World Health Organization recommending telehealth for the rapidly expanding community needs for mental health services, as it can increase access to specialised healthcare provider knowledge and greater equity in care delivery (Tarlow et al., 2020).

Being online for the provision of Clinical Supervision was considered to be a largely positive experience for allied health participants (Bruce et al., 2018; Chaisty & Cunningham, 2021; Connell, 2023). For some participants, it was reported as pivotal to helping participants feel more focused in their roles at work with clear boundaries (Chaisty & Cunningham, 2021), it facilitated group emotional responsivity and thoughtful engagement, as well as increased self-disclosure and decreased personal defensiveness (Bruce et al., 2018). Additionally, participants in Connell's (2023) study found an increased awareness of how they appear on-screen which gave them increased self-awareness of how they might present online to families in their care (Connell, 2023).

Studies that were published post-pandemic provided positive messages about the use of online Clinical Supervision, most likely because of the enhanced familiarity with online technologies. Chaisty and Cunningham (2021) used a validated questionnaire, the Supervisory Relationship Questionnaire (SRQ), and an additional seven open-ended questions exploring 12 psychologists' experiences of online Clinical Supervision. Even though this study was measuring experiences of online Clinical Supervision it should be noted that the SRQ was developed for in-person Clinical Supervision evaluation. Some respondents' answers reflected this,

noting that the questionnaire more accurately captured their feelings about in-person Clinical Supervision. However, the authors acknowledged this with one of their objectives being to explore the suitability of a standard Clinical Supervision evaluation tool suitable for online supervision evaluation. There is no specific validated tool available for the evaluation of online Clinical Supervision. One of Chaisty and Cunningham's (2020) stated aims was to seek feedback on how to improve the practice of online Clinical Supervision in order to provide feedback to management on the experience of online Clinical Supervision. They found that there was a relative ease in organising regular Clinical Supervision sessions at times that were convenient to both the supervisor and supervisees when using an online platform. The mixed methods study included 12 clinical psychologists, based in the United Kingdom (UK), who had all experienced online Clinical Supervision, having moved to the virtual space from in-person delivery due to the onset of the COVID-19 pandemic. The overall findings were positive towards online provision of Clinical Supervision and asserted that the participants found that having an already established supervisory relationship prior to moving online was important, and that building a new supervisory relationship online was more challenging (Chaisty & Cunningham, 2021). Soheilian (2023) recognised a limitation in their study in that they did not collect the specifics of the telesupervision, whether it was online, voice only, group or individual Clinical Supervision (Soheilian et al., 2023).

Flexibility of organising Clinical Supervision was found within a number of included studies. Soheilian et al (2022), Chaisty and Cunningham (2021), and Howard and Peirson (2024) noted the increased flexibility that online Clinical Supervision provided, with increased scheduling options, location and time all showing benefits for supervisees (Chaisty & Cunningham, 2021; Howard & Peirson, 2024; Soheilian et al., 2023). In their study with social workers in the UK which included 22 completed online surveys and eight interviews, Connell (2023) found that virtual supervision was an efficient use of time, freeing up more time for clinical work than attending in-person supervision (Connell, 2023).

Challenges of online for Clinical Supervision

Despite there being positive reflections on using technology for online Clinical Supervision in the available research, there was widespread recognition of the limitations. Technical difficulties (either because of the skill of the operator or reliability of the internet reception) could impact the experience of the session, disrupt the flow of conversation, and lead to miscommunication and misunderstandings (Chaisty & Cunningham, 2021; Howard & Peirson, 2024; Soheilian et al., 2023; Tarlow et al., 2020). Chaisty et al. (2021) found that participants (NHS psychology staff in the UK) were largely positive about their experience of online Clinical Supervision, but as stated above, the questionnaire used in the study to evaluate the Clinical Supervision was intended for in-person supervision, so the results are both potentially problematic and lacking in specific relevance to the Australian midwifery community. Anticipating technical issues and having a 'Plan B' (should the online platform fail) and maintaining a flexible attitude were seen as conducive to effective online Clinical Supervision (Chaisty & Cunningham, 2021).

One of the challenges found was that online rather than in-person delivery could also make it harder to stay focussed during discussions, however, it was also noted that for some participants the online platform made it easier to stay on the topic (Chaisty & Cunningham, 2021). Connell (2023) noted that some participants really felt a sense of loss when transitioning to an online medium, missing the in-person contact, although overall they felt well supported by the online Clinical Supervision (Connell, 2023). The author acknowledged the small sample in their study, and that it was limited to one profession (social work), although this was the case for most studies included in this literature review. Connell (2023) also recognised that specific training to support Clinical Supervisors in the use of online technology for the provision of Clinical Supervision would be supportive and beneficial (Connell, 2023).

Supervisory relationship

Online Clinical Supervision was perceived to be more effective if the participants had previously established a good working relationship prior to going to an online space. Three of the included papers acknowledged that online platforms made it harder to forge effective supervisory relationships, with many of the participants having already established their relationships in-person prior to the move to online Clinical Supervision (Chaisty & Cunningham, 2021; Connell, 2023; Tarlow et al., 2020). Chaisty and Cunningham (2021) found that less attention was paid to unspoken feelings and anxieties, but that overall, the online supervision provided a greater focus with less distractions.

Tarlow et al. (2020) noted that in-person Clinical Supervision was useful for establishing a supervisory relationship before transitioning to online Clinical Supervision (Tarlow et al., 2020). Chaisty and Cunningham (2021) also recommend that ideally the supervisor would have met in person with the supervisee on at least one occasion before commencing online Clinical Supervision (Chaisty & Cunningham, 2021). Chaisty and Cunningham's 2021 study, including 12 clinical psychology practitioners receiving online supervision (described as remote supervision) recommended the prior meeting between supervisor and supervisee to forge the professional relationship, as they found that the online forum could negatively impact the development of the supervisory relationship. Meeting prior to the first Clinical Supervision session appeared to mediate this (Chaisty & Cunningham, 2021).

Non-verbal cues

Using online platforms may prevent supervisors being aware of non-verbal cues from participants, which could limit the impact of online Clinical Supervision. Four papers discussed non-verbal cues in their studies (Bruce et al., 2018; Chaisty & Cunningham, 2021; Connell, 2023; Williams et al., 2022). The online platform generally presents the head and face of the participants, losing access to visualising body language (Chaisty & Cunningham, 2021; Connell, 2023; Williams et al., 2022). However, many participants reported that they were able to find more

effective communication styles that overcame any loss of connection with non-verbal cues, with recognition that online platforms such as Skype™ or Microsoft Teams™ engage both sight and sound and thus minimise the risk of missing non-verbal cues. Facial expressions were easily visualised with the face being so prominent on-screen (Bruce et al., 2018; Chaisty & Cunningham, 2021). Bruce et al. (2018) noted that being able to see each other's faces enhanced the verbal communication, and increased sensitivity to non-verbal cues, especially expressions of confusion or distress (Bruce et al., 2018). Williams (2022) considered the transition from in-person to online groups, and the challenge of the "whole self" being reduced to a face in a small box, with a suggested solution of the facilitator explaining to the online group the limitations of the online platform to try and mitigate potential clumsiness. They discuss the limitations being related to emotional containment that in-person groups can achieve with posture and eye contact, but at the same time posited that being close to each other's faces might give an increased sense of togetherness and a heightened sense of becoming attuned to each other (Williams et al., 2022). Connell's (2023) study found some participants felt a sense of loss around the change from in-person Clinical Supervision, but the advantages of the online experience mediated this loss, although one participant was concerned with the loss of body language which they felt could lead to misunderstandings (Connell, 2023). Other studies also had difficulty with this aspect. For example, some of the 13 student nurses in Howard and Peirson's study (2024) were reluctant to turn their cameras on, which led to some reflections from the students that in-person was superior to online provision of Clinical Supervision, and ironic statements that it was unhelpful not being able to see each other's facial expressions and body language when cameras were not utilised (Howard & Peirson, 2024). The participants found the silences online uncomfortable. The researchers also found the silences challenging, especially with the students not using their cameras, it was unclear whether the silence was due to technical or interpersonal issues. The researchers, who were also the Clinical Supervision facilitators, also found they then had to tune in to the nuances of the voice, recognising the silence, non-decipherable sounds, sighs, and stutters

as non-verbal cues. In their online focus groups, the authors explored the student's discomfort and subsequent finding of safety in the anonymity of participating in the online chat function. Despite this discomfort, their findings demonstrated positivity towards Clinical Supervision for student nurses, with recognition of the sense of feeling valued by the provision of Clinical Supervision (Howard & Peirson, 2024).

Privacy and Confidentiality Concerns

There were concerns over privacy during the Clinical Supervision sessions that were discussed in two of the included papers. Soheilian et al. (2022) described how because the COVID-19 pandemic necessitated many workers to rapidly relocate to work from home, there were issues concerning confidentiality and privacy for some participants who did not have a private space during the sessions. This was problematic for those who shared small residences with roommates or family members. They also found that for some supervisees, there were disruptions from supervisors' family members (children) distracting them from the reflective work (Soheilian et al., 2023). This was echoed in Connell (2023), where participants' voiced concerns about who might be in the background in their supervisor's environment, and not having any control over this (Connell, 2023). This relates to the level of trust supervisees had in their supervisor to ensure their privacy was maintained within the online space. Developing this trust by reiterating the importance of privacy and confidentiality at each session is one of the important aspects of the preamble before each Clinical Supervision session begins.

Skill of supervisor

Due to the challenges of online Clinical Supervision, some of which are described above, the supervisors' skills in conducting Clinical Supervision sessions were important. Tarlow et al. (2020), found minimal difference in efficacy between online and in-person delivery of Clinical Supervision if supervisory skills were advanced. They identified these skills as being open, supportive, and having possession of good communication skills. They utilised two outcome measures in

their study, the Supervision Satisfaction Questionnaire (SSQ), an 8-item Likert response survey, and the Supervisory Working Alliance Inventory, a 19-item Likert measure. The authors found that measures of satisfaction with the supervisory relationship remained high for telesupervision, noting that there had been a well-established relationship prior to Clinical Supervision moving to an online platform, an important factor to note as their results may have differed if a new group had been created for the study, without the prior relationship (Tarlow et al., 2020). The qualitative data in the study by Tarlow et al. (2020) was elicited via telephone interviews, and then an open coding scheme was used to identify themes. During their individual phone interviews, all three participants noted that an effective supervisor must be familiar with the technology for online Clinical Supervision in order to deal with any issues that potentially arise (Tarlow et al., 2020). They found that over time, confidence with the technology reduced these issues. Tarlow et al. (2020) found that the skill of the supervisor was the important element in how effective telesupervision was in comparison with in-person delivery, but that overall, the differences between both modes of delivery were minimal. However, caution is required when generalising these results due to the small sample size. The finding that differences between in-person and online delivery of Clinical Supervision were minimal was echoed in Connell's (2023) study which examined this topic during the COVID-19 pandemic (March 2020-January 2021) in London, UK. Data were collected via a de-identified online survey (completed by 22 child and family social workers) and eight semi-structured one-to-one interviews. The survey was constructed by the researcher using elements commonly used in Social Work Clinical Supervision, and as such was not a validated tool. This is important to note, as the use of a validated tool would lend greater credibility to their findings. Both Tarlow et al. (2020) and Connell's (2023) studies identified the requisite skills of the supervisor as being open and supportive, with the need for good communication skills. They also found that measures of satisfaction with their supervisory relationship remained high for telesupervision, noting that there had been a well-established relationship before Clinical Supervision moved to an online platform (Connell, 2023; Tarlow et al., 2020). Similar positive feedback was

given by the supervisees in a study by Williams et al. (2022), and this was consistent with those who attended in-person sessions. In line with other studies, Williams et al. (2022) also found the supervisor role to be more challenging in the virtual realm, with additional challenges in reading the room, and being able to recognise non-verbal cues as discussed above (Williams et al., 2022). Their reflective study was based in the UK with social workers who participated in small groups for Clinical Supervision, conducted in-person for two years, and transitioned to online delivery for another one year. The themed reflections were drawn from the participants' formal feedback, anecdotal feedback and from the facilitators of the groups (Williams et al., 2022).

The skill of the facilitator in providing a safe space for supervisees online was paramount. To enhance the sense of safety for participants, Soheilian et al. (2022) emphasised that supervisors should receive formal training in the provision of online Clinical Supervision to ensure the delivery of safe and effective support to supervisees. This training could incorporate skills with technology.

Issues with technology

Prior to the COVID-19 pandemic, minor issues with access, connectivity and lack of confidence with online media were generally more common (Bruce et al., 2018; Soheilian et al., 2023). In contrast, the studies published after the onset of the COVID-19 pandemic recognised the sudden pivot to online for most professions, and the subsequent increase in technological expertise and access to the requisite equipment (Chaisty & Cunningham, 2021; Tarlow et al., 2020). It was recognised that there was a necessity to continue to provide care to clients, and for staff to attend training and meetings, hence access to and confidence with a quality online space was required. People had no choice but to embrace these new technologies in order to stay connected during mandated lockdowns. However, despite this ideal switch to the online space, studies have reported ongoing issues such as unreliable internet connection, with interruptions to online Clinical Supervision disturbing the flow of discussion, or deep reflection (Howard & Peirson, 2024; Soheilian et al., 2023; Tarlow et al., 2020). The increase in time spent on online platforms was also noted to contribute to a sense of

"Zoom™ fatigue", where participants reported a sense of exhaustion after a long day of varied online meetings, which could contribute to a decline in mental health (Connell, 2023; Soheilian et al., 2023). Connell (2023) also found that the fatigue associated with back-to-back online meetings with little or no break between could inhibit participants being deeply reflective or open in sessions (Connell, 2023).

Summary

This literature review has shown that there is limited evidence relating to the topic of online Clinical Supervision for midwives. The available evidence suggests that, with careful attention to the supervisory relationships and communication, there is scope for Clinical Supervision to be provided online. Future research needs to be focussed on Clinical Supervision provided online for midwives, because there will be an ongoing use of virtual platforms, but also to increase accessibility for midwives who work in regional and remote areas.

The following chapter will describe the mixed methods methodology and the context of our study. It will include a discussion of the ethical requirements for our study and explore the issue of reflexivity. Data collection and management will be outlined.

Chapter Two: Methods

This research aimed to explore how acceptable online Clinical Supervision is for midwives and gain information on their experiences of the supervision. This chapter will outline the methodology and design of this research project. The study design, the settings, and the methods of data collection and analysis will be described. Reflexivity will also be explored. Ethical issues such as the secure storage of data and informed consent will be addressed.

Research question

What is the acceptability and experience of online Clinical Supervision for midwives?

Research design summary

The study evaluated Clinical Supervision delivered to midwives via a secure virtual platform in two regional health districts in New South Wales, Australia. The study design was mixed methods, with an online survey and individual semi-structured interviews. This study employed a concurrent transformative design which allowed for simultaneous qualitative and quantitative data collection and analysis to gain further insight into the subject (Kroll & Neri, 2009). The use of mixed methods research has been found to provide stronger evidence, adding additional depth and breadth to the findings by integrating qualitative and quantitative methodologies (Dawadi et al., 2021; Lall, 2021).

Participants and recruitment

This study sought participants from two Local Health Districts (LHD) in NSW – the Mid North Coast LHD and the Illawarra Shoalhaven LHD (see Map in Figure 3). The Mid North Coast Local Health District (MNCLHD) is located on the coast of New South Wales (NSW), Australia and covers an area of 11,335 square kilometres. It services a population of over 220,000 people and has one of the fastest growing and ageing populations in NSW (Health, 2024b). Due to the geography and distances from large cities, rural and regional areas can have unique challenges in accessing education and support measures. Facilitating an online support strategy was of interest due to these factors.

The MNCLHD has 12 community health centres, and seven hospitals, four of which have maternity services: Coffs Harbour, Kempsey, Macksville, and Port Macquarie (Health, 2024b). Their birth rate at the time of the study was approximately 2247 per annum, with 14% of births among Aboriginal and Torres Strait Islander mothers (2019) (*HealthStats NSW*, 2021). The hospitals are quite geographically separate, with distances between the sites being up to 153kms (Coffs Harbour to Port Macquarie). This setting had been chosen due to the MNCLHD midwifery manager's interest in initiating Clinical Supervision in their LHD.

The Illawarra Shoalhaven Local Health District (ISLHD) is located on the South Coast of New South Wales and has a population of approximately 404,000, which much like the mid north coast is rapidly growing. The LHD covers an area of roughly 5690 square kilometres. There are two birthing sites within ISLHD, Wollongong Hospital and Shoalhaven District Memorial Hospital, which are 79kms apart. Their combined annual birth rate at the time of the study was approximately 4500 per year, with 5.9% of births among Aboriginal mothers in 2019 (*HealthStats NSW*, 2021).

Preliminary discussions were conducted with the Midwifery Manager from the MNCLHD, who was aware and supportive of this project. The original plan was to train some of the local midwifery staff to facilitate the Clinical Supervision sessions, to ensure sustainability for the provision of this support strategy for the midwifery workforce. A business case was prepared to apply for funding from the LHD for this training to be provided. This funding was not approved, and the study was redesigned so I could facilitate the sessions.

Initially the research was intended for only the MNCLHD (site A), and two groups of midwives were invited, both from within the Midwifery Group Practice (MGP) at two of the hospitals within this area. The MNCLHD midwifery manager suggested that midwives working in the MGP model of care should be approached to participate. The MNCLHD, at the time of the study, employed approximately 150 midwives, of which 12 worked within MGP, across two sites (six MGP midwives in

each site). It was anticipated that potentially all 12 MGP midwives may respond to the offer of participation, and this number (12) has previously been found to be a reasonable sample size to reach data saturation in relation to the open-ended questions that are asked within a survey (Sim et al., 2018). In early conversations with the Midwifery Manager at MNCLHD, it was agreed that the MGP midwives would be better able to organise their workdays to facilitate attendance at the Clinical Supervision sessions due to their autonomous roles (as opposed to core clinical midwives within the wards/units of the public hospitals). Initially, it was anticipated that each month a group of four to six midwives would attend the sessions. More specific attendance numbers and dates of sessions were then co-created with the midwives and midwifery managers. The preferred day/time was chosen to coincide with the regular team meeting when all staff were rostered on. It was planned that the groups would be organised for each team to attend together. This was both for ease of scheduling, and to provide the opportunity for addressing any team issues in the sessions. The invitation was extended to twelve midwives via an email sent by a third party within the health district.

Participants were then sought from another site (Site B, ISLHD), due to having commenced online Clinical Supervision sessions with a group of seven Early Career Midwives (ECMs) at this LHD. Seven midwives from Illawarra Shoalhaven LHD, who had started to attend online Clinical Supervision sessions with me as their facilitator, were invited to participate in the study. The Illawarra Shoalhaven district employs approximately 180 midwives. Whereas the MNCLHD midwives were invited to attend Clinical Supervision sessions and complete a survey/attend an interview, midwives from ISLHD were invited to complete the survey/interview only, due to their existing online Clinical Supervision with me, over the previous seven months. The ISLHD group was made up of early career midwives in their first year of practice, rotating across the service in core midwifery roles in all key areas; antenatal clinic, birth unit and the maternity ward.

A total of 19 midwives were invited to participate in the study, and fifteen accepted this invitation, with nine from MNCLHD and six from ISLHD consenting to be part of the study.
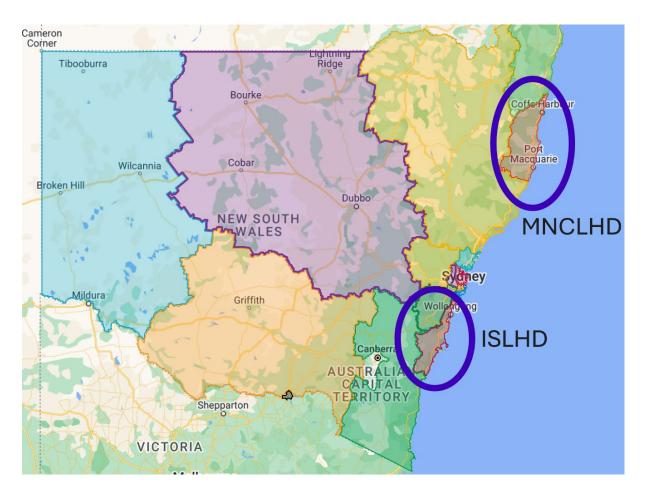
Figure 3: Map showing ISLHD & MNCLHD

Measures

Acceptability was measured through participant responses to an online survey, and individual semi-structured interviews (see Table 3). The survey contained questions from the Clinical Supervision Evaluation Questionnaire (CSEQ) which recorded the midwives' perceptions and experience of the Clinical Supervision (Horton et al., 2008). The survey also contained open ended questions to elicit the midwives' experience of attending the Clinical Supervision sessions online. These questions were formulated using the elements of the Theoretical Framework of Acceptability (TFA; Sekhon et al., 2018). The survey was designed and hosted on the REDCap platform, which facilitates both the sharing of the survey to the participants and secure storage of responses. Participants were also invited to participate in individual qualitative interviews to gain further insight into their experience of the online provision of Clinical Supervision.

Table 3: Mixed Methods Data Collection

Quantitative	Qualitative
Clinical Supervision Evaluation Questionnaire (n = 11)	Theoretical Framework of Acceptability (n = 11)
Attendance at supervision (3 groups – total = 15 participants)	Semi-structured Interviews (n = 6)

Acceptability

Acceptability is increasingly being considered an important factor when implementing healthcare interventions. It is seen as an essential element when evaluating the effectiveness of an intervention, and it applies to both the providers of the intervention and the recipients. Acceptability is recognised as a complex concept to define due to the varying definitions within healthcare literature, and the way acceptability is perceived can change according to the experience of the intervention (Sekhon et al., 2018). For the purposes of this project, the understanding of acceptability was the appropriateness of the online platform for the provision of the Clinical Supervision, the suitability to fit into the midwives' life/work, and the convenience and effectiveness of the online platform (Sidani et al., 2009).

The Clinical Supervision Evaluation Questionnaire (CSEQ)

Developed by Horton et al. (2008), the CSEQ (see Appendix 3) is a validated tool to measure perceptions of supervision as a support strategy. The CSEQ was developed to measure the *purpose*, *process*, and *impact* of Clinical Supervision for healthcare practitioners. It is a self-administered questionnaire and thus easy for participants to complete anonymously and online. The tool has been used in numerous studies examining the perceptions of Clinical Supervision within the health care professions (Dungey & Bates, 2021; Francis & Bulman, 2019; Gabrielsson et al., 2019; Gardner et al., 2021). It is a short evaluation tool (14 items) which has been shown to be suitable for a diverse range of health professionals and is applicable to small studies (Horton et al., 2008). Gardner et al.'s study (2021) showed the CSEQ to have acceptable internal consistency in its development with a cohort of UK speech and language therapists. Acceptable internal consistency was also demonstrated with a large cohort of Australian allied health professionals (Green & Cappleman, 2023), and mental health professionals in a version translated into Swedish (Gabrielsson et al., 2019). The CSEQ has also been shown to have acceptable convergent validity and factor analysis supporting it's 3-factor structure (purpose, process and impact; Dungey & Bates, 2021; Francis & Bulman, 2019; Gabrielsson et al., 2019; Gardner et al., 2021). The CSEQ was developed to evaluate in-person provision of Clinical Supervision, but in the absence of a specific tool to evaluate online provision, it was considered to be highly appropriate for this study, to gain insight into the midwives' perceptions of the Clinical Supervision provided online. Data were analysed using a specific CSEQ scoring system using whole positive integers for simplicity (Gardner et al., 2021; Horton et al., 2008).

CSEQ – scoring

The survey responses were all exported to Microsoft Excel™ and tabulated to enable scoring. The scoring of the CSEQ gives a numerical value to each response on a 5-point Likert scale, varying from *strongly agree*, scoring five to *strongly disagree* scoring one, with *no opinion* attracting three, as per the method used by both Kuipers et al. (2013) and Gardner et al. (2021). This method of scoring

was chosen to enable easy comparison. With this method a maximum score would be 70 (if participants checked *strongly agree* for all statements, which equates to the 14 statements multiplied by five), and similar to Gardner et al. (2021) we considered a score of 56 or above would show a positive perception of the Clinical Supervision. In contrast a total score of 41 or less denotes a negative perception of the supervision experienced. Scores between 42 and 55 represent a neutral response (Gardner et al., 2021; Kuipers et al., 2013).

Other tools that were considered for this research included the Manchester Clinical Supervision Scale (MCSS), but the cost of using this was prohibitive, as well as the scale being significantly longer (26 questions). The MCSS is also recommended to be used after participants have attended a minimum of six sessions, which was unlikely to be realistic in the current study for all participants (Winstanley & White, 2011). It was felt to be unlikely due to the nature of midwifery work and rostering, over six months the midwives would have annual leave, sick leave, night duties, competing clinical duties and for the MGP midwives there would inevitably be births conflicting with the scheduled Clinical Supervision sessions. Another tool that was considered was the Generic Supervision Assessment Tool (GSAT), but it was in the process of validation for individual supervision at the time of creating this research design and has not been researched for group supervision to date, hence not appropriate for the current study. The Leeds Alliance in Supervision Scale (LASS) was another tool that was considered. This is a brief validated tool, more suited to a discussion between supervisor and supervisee at the end of a session than the requirements of the current study (Wainwright, 2010).

An online survey link to the CSEQ was sent to participants on conclusion of all the supervision sessions. As well as the CSEQ, data were collected on items related to the impact of the Clinical Supervision sessions (see Table 4). The majority of the open-ended questions related to the acceptability of the online sessions using the Theoretical Framework of Acceptability framework (Sekhon et al., 2018).

Theoretical Framework of Acceptability

The *acceptability* of an intervention, and what this means to participants, is a necessary consideration to measure how any intervention is received, whether provided in-person or online. The Theoretical Framework of Acceptability (TFA; Sekhon et al., 2018) was utilised in this project to assess the acceptability of online supervision across seven domains: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, costs, and self-efficacy. Within the online survey, response boxes were provided for free text answers (see Table 4). The survey contained prompts for some of the questions to ensure participants understood and were better able to answer the questions. For example, the question "How does online Clinical Supervision align with your professional values?" had the following text below the question, "For example, engaging in reflective practice, or continuing professional development". The TFA survey questions and prompts are presented in Table 4.

The TFA was chosen for this study because it provided a validated and straightforward framework around which to build the qualitative questions for the online survey. It was acknowledged that the focus of the TFA should be based around the participants' experience of the intervention.

The TFA has been used in a variety of studies such as a Canadian examination of a men's mental health promotion group (Murphy & Gardner, 2019), an evaluation of a community-based action team in Ghana (Hornuvo et al., 2022), and an examination of the acceptability of a postnatal walking group in London (Pavlova et al., 2020).

Table 4: TFA Components and Survey Questions

TFA component	Survey Question
Affective attitude – how the participant feels about the intervention	How do you feel about attending the Clinical Supervision sessions using online?
Burden – how much effort is required to participate in the intervention	How much effort does it take for you to attend the Clinical Supervision sessions online?
Ethicality – How much the intervention 'fits' with the participant's values	How does the online Clinical Supervision align with your professional values?
Intervention coherence – how much the participant understands the intervention and how it works	What is your understanding of how the Clinical Supervision sessions work?
Opportunity costs – how much the participant has to give up in order to participate	What have you had to give up in order to attend Clinical supervision? For example: Did you have to leave work early? Did you have to miss a family/friend activity? Did you have to pay anything to attend?
Perceived effectiveness – how much the participant thinks the intervention is likely to succeed	How effective do you think online Clinical Supervision has been?
Self-efficacy – how confident the participant is that they can perform what is required to take part in the intervention.	How confident do you feel about taking an active part in online Clinical Supervision?

Semi-structured interviews

Further to completion of the survey, all the participants were also invited to participate in an individual online interview. These interviews sought to expand on the open-ended questions asked within the survey (see the interview questions in Appendix 5). It was anticipated that approximately four to six midwives would agree to be interviewed from the larger group of participants who attended the Clinical Supervision sessions and completed the surveys. Four to six interview participants were thought to be sufficient to gain information regarding expansion

of the survey questions. Data from this number of participants would not necessarily reach saturation, but instead the aim was to complement the survey responses and add nuance and explanation in relation to acceptability of the online Clinical Supervision sessions. Data saturation is reached at the point in the research process when there is no new information being provided, and the researcher is confident that continued collection would provide similar results (Faulkner & Trotter, 2017). It is generally acknowledged that the first four to six interviews produce the majority of information, with most new information being gained early in the process (Guest et al., 2020).

Procedure

Twelve midwives from the MNCLHD and seven midwives from ISLHD were invited to participate in the study via an informational recruitment flyer (see Appendix 1b) sent to all potential participants by their manager. The flyer outlined the details of the study and the benefits of Clinical Supervision. Participants were asked to attend monthly online Clinical Supervision sessions over a period of six months (six sessions). Six months was considered to be a realistic length of time, given the constraints of a master's degree. It was anticipated that the participants would have attended enough sessions for them to be able to form an opinion on the online provision and on the supervision provided. Six sessions were found to be sufficient to show a difference in a similar previous study (Wallbank, 2010). Clinical Supervision was provided monthly to fifteen midwives across three groups (two within Site A and one within Site B) for a total of six months concluding in March 2023. Once the Clinical Supervision provision over the six-month period was completed, all participants were asked to complete the online survey in March 2023, and were invited to attend an interview. Prior to being interviewed, participants were asked to complete a consent form to confirm their agreement. Interviews were conducted between March – May 2023.

Clinical Supervision Model

Participants were invited to attend Clinical Supervision sessions that offered regular support and reflective practice. The sessions were designed to be closed groups, with the same midwives in each group, recognising that each

month the make-up of the group might vary slightly due to other commitments. Suitable days and times for sessions were negotiated with the participants. The preferred platform chosen by both the LHDs included was Microsoft Teams™, for ease of access on NSW Health devices. Time was taken in the introductory group sessions with potential participants to explain Clinical Supervision and build trust.

The model of Clinical Supervision facilitated at both sites was the Role Development Model, created by Mike Considine in the 1980s (Harvey et al., 2020). This model employs elements of psychodrama to enable deep reflection with the emphasis on exploration of emotions, thoughts and actions rather than problem-solving. Supervisees are guided to consider issues in new ways, and the focus is on constructive processes, with a variety of techniques available to facilitate reflection and move forward. I am an accredited facilitator of Role Development Clinical Supervision, having attended basic and advanced practitioner training (Clinical Supervision Consultancy, 2024). The training received was based on in-person provision of Clinical Supervision, despite being provided largely during the COVID-19 pandemic. Because of this, there was an online application being developed to enable use of some of the figures and props that are frequently utilised with the Role Development model. However, at the time that the Clinical Supervision was being provided for this study, this application was in the early stages of development, and it was felt that using it may prove distracting and difficult. The focus was to ensure that the sessions provided were low stress and safe. I also wanted to be able to evaluate provision of Clinical Supervision via an online platform rather than the use of any other technological aspects. The Role Development model can be used in different ways, using play of life three dimensional figures (Playmobil™ figures – see appendix 10) is a common approach based on the work of Carlos Raimondo. However, due to being online for this study, we chose to use role theory to guide the discussions using a white board to capture the discussion as the roles evolved. A small portable whiteboard was used to document words, emotions, resolutions and suggestions. There was also a range of magnets that could be used, such as emojis and two-

dimensional figures (see Appendix 10 for pictorial examples). The whiteboard could be easily visualised by the supervisees on the supervisors screen.

The way that supervisees accessed the sessions did vary across the period of the study. Some supervisees were fortunate to have access to an individual laptop with a camera and microphone, as well as a private space to join from. For others there was a need for two or three midwives to join from a single laptop. Other midwives joined from their phone or laptop, either from their car or their home. This was not necessarily a design of the study, but organised on a purely pragmatic basis to suit the midwives involved.

Facilitator Preparation

Prior to commencing the sessions within the study, I had been providing group Clinical Supervision both in person and online to small groups of midwives for a few months. During the course of the study, I was providing up to seven groups per month, both in person and online. Prior to the study I had facilitated many groups for childbirth education to pregnant women and their support people, and training workshops to midwives, nurses and doctors over a few years. With the advent of the Covid-19 pandemic, many of these courses pivoted to online platforms. I was confident with group facilitation and the online space, and comfortable with facilitation of group Clinical Supervision, as the training I received was comprehensive. A supervisor with many years of experience, particularly with online platforms, may have achieved different results,

Reflexivity

As the researcher on this study, in addition to the facilitator of the Clinical Supervision sessions and the interviewer of the participants, reflexivity was an important aspect of the study. Reflexivity is the consciousness of the core beliefs and values that the researcher holds, and the way in which they impact the way that the research is carried out. An awareness of the self in relation to the participants and their interactions with the researcher helps to deepen understanding of the data and is integral to any qualitative enquiry (Reid et al., 2018; Burns et al., 2012).

As a midwife, especially one with Midwifery Group Practice (MGP) experience, and as a woman, I had a privileged position as an *insider* which can both facilitate ease of acceptance within the group of participants and highlight the commonality between the researcher and the participants (Burns et al., 2012). An awareness of the "story behind the story" facilitates greater understanding of the relationship between the researcher and the research (Burns et al., 2012). As midwife-researcher and as facilitator of the Clinical Supervision groups, I needed to recognise and allow for personal bias and expectations. Methodical self-awareness is key to understanding the unfolding of these biases and preconceived ideas during the research journey (Maso et al., 2003).

Being employed as a midwife in Maternity Services within Illawarra Shoalhaven LHD at the time of the study, there was an additional level of insider status with the group of midwives recruited at this location. I needed to create distance with this group in order to enhance my credibility as facilitator and researcher. It was also crucial for me to consider my beliefs and views in order to reduce any personal bias (Steen & Roberts, 2011). I also needed to consider the role I played in the research process, and the analysis of the data, to try and remain sensitive to meanings that I might attach to themes and meanings that may emerge (Deggs & Hernandez, 2018; Munhall, 2012). To maintain integrity in the research process, I also needed to have an intention to engage reflexively and be prepared for any negativity (Olesen, 2011). I was keenly aware of the need to reflect on, and analyse any negative responses, but not take it personally. It was strongly communicated to the participants that their responses to the survey were anonymous and would not affect their professional relationships in any way. Prior to each interview the *research* focus of the interview was emphasised, and interviewees reassured that they should answer with honesty, that no offence would be taken with any negativity. At the time of the study, I was not a member of the ISLHD core midwifery clinical team, and thus did not work directly with any of the participants.

A password protected online journal was kept during the period of the Clinical Supervision sessions being provided, and during the interview period.

These notes comprised field notes and provided additional data to provide context, and aid reflexivity. Additional relevant information was provided such as noting any technical issues. Field notes are recommended during qualitative research, recognising the rich context and additional data provided (Phillippi & Lauderdale, 2018). The framework utilised to guide these field notes was the Role Development Supervisor Reflection Guide (see appendix seven). This framework encouraged broad reflection about the technology, the session structure, what techniques were employed and what went well and any challenges for the supervisor. The reflections also focused on the supervisees responsiveness/emotions and moods and how effective the process was for the groups.

Data analysis

Eleven supervisees completed the online survey and six agreed to participate in an individual online interview. The six that consented to the interview were mixed across the three groups, with three from MCLHD, and three from ISLHD. There were three who worked in MGP and three early career core staff midwives, and mixed ages. The responses to the CSEQ were evaluated using the recommended scoring (see Appendix 3b) (Gardner et al., 2021). Simple descriptive statistics were used to analyse these data.

The online interviews were audio recorded and transcribed verbatim to ensure accurate recording of data. All data were deidentified with the identifiers Int01 to Int06 used for the interview data, and S1-S11 added for the survey data. In addition, there were recorded reflections on the facilitator role from each Clinical Supervision session in a password protected online diary. All data from interview transcripts and the TFA survey responses were integrated. By transcribing the interviews personally, the data became very familiar. Data were then coded with several more read-throughs to become more familiar with the participants' responses. Data and codes were also reviewed by two senior researchers (research supervisors) to strengthen and broaden the themes. Thematic analysis was carried out for the responses to the qualitative questions within the survey

and the interviews using the six-step approach to the analysis and interpretation of qualitative data (Braun & Clarke, 2021):

1. Become familiar with the data by fully immersing yourself - transcribe the interviews or other interactions and re-read the transcripts and then build a comprehensive understanding of all the content. I had conducted all the interviews myself, and then transcribed them, and thus was intimate with the data. Re-reading and discussing with the research supervisors further enhanced familiarity.

2. Generate initial codes – identify the parts of the data that appear to be interesting or meaningful – the preliminary codes may be numerous and more specific than the themes. Initial codes were developed by highlighting certain words and phrases within the data and then discussed with the research supervisors at length.

3. Search for themes – begin interpreting the generated codes. In consultation with my supervisors, we started to develop early themes, such as valuing Clinical Supervision.

4. Review themes – all the themes and sub-themes were tabled, with further discussion, exploration, and elaboration of initial themes.

5. Define and name themes – this phase is where the data is further refined, and then final themes (and potential subthemes) are identified and enhanced. The research team started to name the themes and develop the sub-themes, with a deeper understanding of the meaning attached.

6. Write the report using data analysis to relay the results. Data extracts should be used to illustrate the themes and help to tell the full story (Braun & Clarke, 2021).

Triangulation

An important aspect of mixed methods research is data triangulation. Triangulation allows for a more holistic approach to interpretation of the data and enhances the validity of the findings (Arias Valencia, 2022; Renz et al., 2018). We

used methodological triangulation, using a survey with qualitative and quantitative tools, and qualitative interviews to collect data. This was used to reduce researcher bias and the limitations of using a single data collection method, thereby strengthening the findings and encouraging completeness of the data.

The quantitative data from the CSEQ gave insight into the participants' evaluation of the Clinical Supervision they had received, which were examined alongside the qualitative responses within the survey. The qualitative interviews provided an opportunity to further examine the participants' experience of attending online Clinical Supervision. The interviews gave individual participants space to share their reflections of the online technology, highlighting any specific issues which enhanced or limited their experience. The thematic analysis combined the themes from the qualitative data from the interviews and the open-ended survey questions, which were further explored alongside the results of the CSEQ. For example, the process section of the CSEQ refers to the participants sense of safety, with items such as "I feel safe sharing clinical issues in supervision sessions", and "I feel confident about bringing issues to Clinical Supervision".

Ethical requirements

Permission was required from both LHDs to recruit midwives to participate in the research. Concurrently, ethical clearance was sought and approved by the MNCLHD (MNCAR-2022/3), ISLHD (AR22/004), and UTS (HREC: ETH22-7201) (see Appendix 6).

All participants received a Participant Information Sheet (PIS) outlining the risks and benefits of participating in the research project. After reading this, the participants were asked to complete the consent form and return it via email prior to attending the first Clinical Supervision session, as required by the UTS HREC and ISLHD and MNCLHD HRECs (see Appendix 1). This PIS included details of what actions would be taken if distress occurred during any of the sessions. There was also a distress protocol developed and included in the ethics applications (see Appendix 1).

Within each LHD the invitation to participate in the study was extended to the group by a third party, in line with ethical requirements from the LHDs. The participants within each group were known to each other, and confidentiality was always discussed and agreed on at the start and end of each supervision session. There was an agreed set of *ways of working* group rules, which were constructed as a group during the first sessions and revisited at the start of each supervision session (see Appendix 7). The participants were invited and encouraged to complete an online survey which would be anonymised and any possible identifying or personal features that may be included as part of the qualitative responses removed.

The small number of participants did make anonymity more challenging, and this is recognised as a limitation of this study. In any publications arising from this study, it was made clear that the participants' privacy and anonymity would be protected. The setting was de-identified, and all participants were given a pseudonym to protect their privacy. Any other identifying features or nuanced demographic features were removed to protect participants' confidentiality.

Participant Resources

Resources required for this project included midwives' access to videoconferencing technology, which in some cases were personal laptops or phones, or hospital equipment within their workplace. They also required quarantined time to attend the supervision sessions. This was negotiated prior to the commencement of the sessions and organised to suit the staff and management.

Data management

All data has been and continues to be securely stored. Consent forms were scanned and stored electronically in the UTS secure data management system (STASH) for 5 years. There has been a research data management system (RDMP) developed (see Appendix 8). The survey data is stored in the University of Technology Sydney REDCap database, which is a secure cloud-based platform, accessible only to the research team.

This chapter has provided the details of the methodology of the current study. The recruitment of participants and the health districts they work in were described. The mixed methods approach, encompassing the quantitative data from the CSEQ online survey, and the qualitative data from the TFA section of the online survey and the semi-structured interview responses has been described. The data analysis and storage has been outlined, as well as the ethical requirements. Lastly, reflexivity has been discussed. The next chapter will discuss the results, examining the data collected from the CSEQ and the themes generated during the analysis of the qualitative data will be outlined and illustrated with quotes from the participants and the field notes.

Chapter Three: Findings

Introduction

Midwives need support in the context of worldwide midwifery shortages and high levels of burnout and work-related stress (Dahlen et al., 2022; Hunter et al., 2019; Nove et al., 2021). During the recent COVID-19 pandemic, many support strategies, such as Clinical Supervision, were cancelled or pivoted to online delivery, with little or no evidence for the acceptability and perception of the online space for such strategies. The aim of this research was to evaluate the provision of Clinical Supervision via an online platform and discover the acceptability and experience of online Clinical Supervision from the perspectives of the midwife supervisees.

This chapter will present the results of the mixed methods study, examining both the quantitative and qualitative data. Quantitative data were collected from the Clinical Supervision Evaluation Questionnaire (CSEQ). The qualitative data were collected through open-text boxes within the online survey and follow-up semi-structured in-depth interviews conducted by me, via Microsoft Teams. Themes and sub-themes from the qualitative data will be presented, and where appropriate, the field notes written during the provision of the Clinical Supervision sessions will be included to give context or further information. The cohort of midwife participants will be introduced using demographic data collected from the online survey.

Two Local Health Districts (LHDs) within New South Wales (NSW), Australia, agreed to participate. For ease we have used the nomenclature of Site A for MNCLHD and Site B for ISLHD data.

Attendance

A total of 15 midwives participated in the Clinical Supervision sessions across the two sites. The sessions occurred monthly for each group with varied attendance. The sessions all occurred over the same period of time, with the

timing arranged to suit the midwives and the service. For example at site B the sessions occurred at 2pm to coincide with an overlap of shift times, to assist attendance. Attendance at the sessions is recorded in Table 5 below, with attendance ranging from one to seven midwives at the Clinical Supervision sessions. For many of the new graduate midwives working in core midwifery roles at Site B, with less autonomy over their roster and workload, sometimes attendance was challenging, for example session six where there was only one participant able to attend. Reasons given (via email or text message) for non-attendance at this session included acuity in the units, working night duty, and annual leave. For the MGP midwives at Site A, attendance was more regular but sometimes impacted by annual leave, or midwives being called in to the birthing environment to provide care to one of their caseload women. Site A group 1 was made up of two midwives only. The other four members of their team were invited to participate but chose not to, and did not attend the early introductory sessions. No data was collected from the four who declined as to why they chose not to attend.

At both sites, some of the midwives had previously attended in-person Clinical Supervision sessions.

Table 5: Attendance at Clinical Supervision Sessions Across Sites

Site	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Average attendance
Site A (group 1) n = 2	2	2	1	1	1	2	1.5 (75%)
Site A (group 2) n = 7	6	5	5	6	5	7	5.7 (81%)
Site B n = 6	6	3	5	4	4	1	3.8 (64%)

Demographics

All participants were female. See Table 6 for demographic information about the participants. Most were aged between 31-40 years of age, with Site B consisting of early career midwives and Site A midwives having more years of experience. Most participants across both sites worked part-time.

Table 6: Participant Demographics

	Total N = 11	Site A N = 6	Site B N = 5
Age (years)			
<30	3	0	3
31-40	4	2	2
41-50	2	2	0
>50	2	2	0
Education pathway			
Hospital-based certificate	2	2	0
Postgraduate degree	5	3	2
Bachelor of Midwifery	4	1	3
Years of experience			
<5	5	0	5
6-10	2	2	0
11-15	0	0	0
>15	4	4	0
Hours of working			
Full time (38)	4	3	1
Part-time (30-32)	7	3	4

Quantitative Data – The CSEQ

All fifteen participants who had attended the group Clinical Supervision sessions were all invited to complete an online survey, with the link sent within a week of their final Clinical Supervision session, eleven participants completed the survey.

The CSEQ (see Table 7) comprises 14 questions exploring the experience of Clinical Supervision, with responses collected on a Likert Scale (Figure 4). The CSEQ scores from the survey showed an overall positive response to the Clinical Supervision provided online as part of the study, with individual participants' total scores varying from 54 to 69 out of 70 (see Table 8). The average (mean) across the individual CSEQ items was 4.33 (out of a possible 5) and the total scores of the two cohorts are reported below, along with the Standard Deviation scores (see Table 8).

Questions within the CSEQ were divided between those that focussed on the purpose of the Clinical Supervision, the process and the impact, explained below.

7. Being part of a clinical supervision group is helping to develop my self-awareness
○ Strongly agree ○ Agree ○ No opinion ○ Disagree ○ Strongly disagree
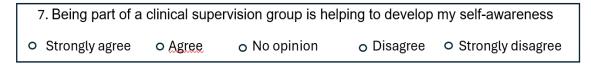
Figure 4: Example of a question within the CSEQ and Likert scale

Purpose

Questions 1 - 3 of the CSEQ focused on the purpose of the Clinical Supervision. The mean score for the three questions which examined the purpose of Clinical Supervision was 4.42, with scores ranging from 4 (*strongly disagree*) to 5 (*strongly agree*). The mean score for question one was 4.65, with all participants responding with either *agree* or *strongly agree* which shows that all participants felt that any confidences they shared were respected (Table 8).

Process

Questions 4 – 8 of the CSEQ examined the process of the Clinical Supervision. The mean score for these five questions was 4.45, with scores ranging from 4 (*strongly disagree*) to 5 (*strongly agree*), the highest scoring subscale of the survey. The trust amongst members of all the three groups was particularly high, with an average rating of 4.75 for question four, with all participants' responses showing strong agreement or agreement with the statement: "There is mutual trust between the members in my group".

Impact

Questions 9 - 14 of the CSEQ reviewed the impact of the Clinical Supervision. This was the lowest scoring subscale of the CSEQ, with a mean score of 4.14 out of the highest score possible of five. However, this score is still in the positive range. The lowest rating question of this part of the survey was question 9, "Clinical Supervision has helped me cope with any stresses at work I may have"*,* with a total score of 43 out of a possible 55, representing an average of 3.92. This question was the only question in the CSEQ which elicited a *disagree* response from one participant (Table 7). In contrast, the responses to question 11, "Clinical

Supervision has definitely had a positive impact on the quality of care I provide", were clearly positive with six of the 11 participants responding with *strongly agree*.

Figure 5 presents the mean results of the subscales of the CSEQ, purpose, process and impact, combining the results for both Site A and Site B. The standard deviation error bars for each of these combined averages are also included. Average ratings for all subscales were in the "positive perception" range (above 4/5) with minimal variation as evidenced by small standard deviation bars.
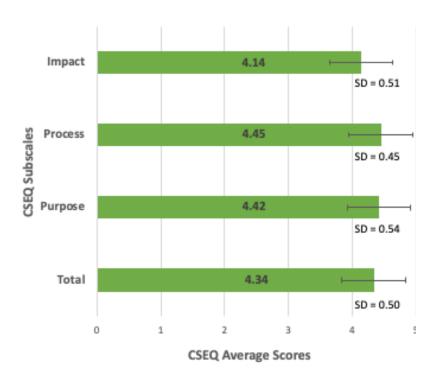
Figure 5: CSEQ average scores with standard deviation error bars

Table 7: CSEQ Questions and Participant Responses

	Adapted CSEQ Questions	Strongly agree			Agree			Disagree			Strongly disagree			No Opinion		
		Site A	Site B	%	Site A	Site B	%	Site A	Site B	%	Site A	Site B	%	Site A	Site B	%
1	I believe that any confidences I share are respected (Purpose)	3	4	63.6	3	1	36.4	0	0		0	0		0	0	
2	Clinical Supervision has helped me feel more confident about dealing with my job (Purpose)	1	3	36.4	3	2	45.5	0	0		0	0		2	0	18.1
3	I have gained new clinical insights through supervision (Purpose)	1	3	36.4	5	2	63.6	0	0		0	0		0	0	
4	There is mutual trust between the members in my group (Process)	3	5	72.7	3	0	27.2	0	0		0	0		0	0	
5	Being part of a Clinical Supervision group is helping to develop my self-awareness (Process)	1	5	54.5	3	0	27.2	0	0		0	0		2	0	18.1
6	I feel safe sharing clinical issues in supervision sessions (Process)	1	3	36.4	4	2	54.5	0	0		0	0		1	0	9
7	The purpose of Clinical Supervision is to enable clinicians to feel confident in their own practice (Process)	1	2	27.2	4	3	63.6	0	0		0	0		1	0	9
8	I feel confident about bringing issues to Clinical Supervision (Process)	3	4	63.6	3	1	36.4	0	0		0	0		0	0	
9	Clinical Supervision has helped me cope with any stresses at work I may have (impact)	0	2	18.1	5	2	63.6	0	1	9	0	0		1	0	9
10	Clinical Supervision has made me more aware of areas of skill I need to improve (impact)	2	1	27.2	2	4	54.5	0	0		0	0		2	0	18.1
11	Clinical Supervision has definitely had a positive impact on the quality of care I provide (impact)	3	3	54.5	1	2	27.2	0	0		0	0		2	0	18.1
12	There are well established ground rules in my group (impact)	1	4	45.5	5	1	54.5	0	0		0	0		0	0	
13	The purpose of Clinical Supervision is to improve care for women and babies (impact)	3	1	54.5	3	2	45.5	0	0		0	0		0	2	18.1
14	I am clear about what I want to get out of Clinical Supervision (impact)	0	0		6	5	100	0	0		0	0		0	0	

Table 8: CSEQ Results

		SITE A (n=6)			SITE B (n=5)			All sites
	Item	Total	Mean	SD	Total	Mean	SD	Mean
1	I believe that any confidences I share are respected *(Purpose)*	27	4.50	0.55	24	4.80	0.45	4.65
2	Clinical Supervision has helped me feel more confident about dealing with my job *(Purpose)*	23	3.83	0.75	23	4.60	0.55	4.22
3	I have gained new clinical insights through supervision *(Purpose)*	25	4.17	0.41	23	4.60	0.55	4.39
	Mean scores for Purpose (Total possible)		4.16 (5)			4.66 (5)		4.416 (5)
4	There is mutual trust between the members in my group *(Process)*	27	4.50	0.55	25	5.00	0.00	4.75
5	Being part of a Clinical Supervision group is helping to develop my self-awareness *(Process)*	23	3.83	0.75	25	5.00	0.00	4.42
6	I feel safe sharing clinical issues in supervision sessions *(Process)*	24	4.00	0.63	23	4.60	0.55	4.30
7	The purpose of Clinical Supervision is to enable clinicians to feel confident in their own practice *(Process)*	27	4.50	0.55	22	4.40	0.55	4.45
8	I feel confident about bringing issues to Clinical Supervision *(Process)*	27	4.50	0.55	24	4.80	0.45	4.65
	Mean scores for Process		4.13			4.76		4.45
9	Clinical Supervision has helped me cope with any stresses at work I may have *(impact)*	23	3.83	0.41	20	4.00	1.22	3.91
10	Clinical Supervision has made me more aware of areas of skill I need to improve *(impact)*	24	4.00	0.89	21	4.20	0.45	4.10
11	Clinical Supervision has definitely had a positive impact on the quality of care I provide *(impact)*	25	4.17	0.98	23	4.60	0.55	4.39

12	There are well established ground rules in my group *(impact)*	25	4.17	0.41	24	4.80	0.45	4.49
13	The purpose of Clinical Supervision is to improve care for women and babies *(impact)*	24	4.00	0.63	19	3.80	0.84	3.90
14	I am clear about what I want to get out of Clinical Supervision *(impact)*	24	4.00	0.00	21	4.20	0.45	4.10
	Mean scores for Impact		4.02			4.26		4.14
	Mean total score for CSEQ	58			63.40			60.70

SD = standard deviation

Qualitative data

Open-ended survey questions

The questions included in the survey were designed around the seven elements of the Theoretical Framework of Acceptability (TFA) (Sekhon et al., 2017). All 11 survey respondents completed the seven TFA questions (see Table 9). The qualitative survey data were then analysed alongside the interview data using thematic analysis.

Table 9: TFA survey responses

TFA Data: Site A (*n* = 6)	TFA Value	S01	S02	S03	S04	S05	S06
1. How do you feel about attending CS sessions using videoconferencing?	Affective attitude	Ok	I do not have a problem using videoconferencing	Feels fine as the group was all present in person	fine	its convenient	Good
2. How much effort does it take to attend the CS sessions online	Effort	challenging based on time constraints	minimal effort is needed	not alot	it's easy at currently scheduled time	little effort	Not too much
3. How does the online CS align with your professional values	Values	ok	i find online clinical supervision very beneficial for my reflective practice,	Reflective practice, active listening, good boundaries, safe space	well	clinical supervision is well aligned with my values.	I think it has helped me to recognise some of my professional values
4. How confident do you feel using the technology required to join the CS sessions	Technology	ok	very confident	very	easy	its usually pretty easy as you just click a link in an email	No problems
5. Did CS interfere with your work or personal activities?	Cost	no	some sessions needed creative juggling of my workload however i find it very beneficial therefore was not in any way negative	Sometimes	no	no it was conveniently timed	No, but didn't make it to all sessions
6. Do you think that attending CS session made you feel more supported/less stressed	Success	yes	it has improved my reflective practice	Absolutely, hoping to continue same as a group	perhaps	I think its great for team building. I'm lucky enough to work in a team that has already worked hard at building trust. BUT clinical supervision is perhaps not so well aligned	After the sessions I felt more energised so I guess it was supportive in that way

TFA Data: Site A (*n* = 6)	TFA Value	S01	S02	S03	S04	S05	S06
						with current needs - anything short of a full system overhaul is just putting bandaids on severed limbs.	
7. Does online CS encourage active participation; did you feel comfortable to speak up	Confidence	yes no issues	yes very active participation though out each session, i will miss working with Helen	Yes, easy to speak up	yes it is actively engaging	Things are always a little harder online but I think in a cohesive team it works well. I could see problems with a team that was in a tough place	Very comfortable

TFA Data – Site B (*n* = 5)	TFA Value	S07	S08	S09	S10	S11
1. How do you feel about attending CS sessions using videoconferencing?	Affective attitude	It allows for greater access when midwives may be on different wards/hospitals etc. It has been a positive experience having easy access no matter where i'm working	Would prefer face to face but easy around childcare commitments online.	Confident	Easy	It was good – felt very easy
2. How much effort does it take to attend the CS sessions online	Effort	Minimal effort, it is easily accessible	Moderate	Difficult with shifts sometimes but attend when able to	Can be hard to get off the floor, especially when short staffed	I preferred to attend when on a day off
3. How does the online CS align with your professional values	Values	It has aligned well, facilitating reflective practice and ability to improve professional practices in a safe way	Aligns well.	Introduced me to a new way of discussing issues	Aligns well	fine
4. How confident do you feel using the technology required to join the CS sessions	Technology	It is simple to use	Confident	Very confident	Confident - easy	Very confident
5. Did CS interfere with your work or personal activities?	Cost	No	Sometimes difficult if on a busy shift.	Sometimes taking 1 hour out of work, or otherwise can't attend	Sometimes – when busy on the floor	Not really – was able to schedule around it
6. Do you think that attending CS session made you feel more supported/less stressed	Success	It has allowed me to reflect on work experience with different approaches and ways to navigate issues. It has been a very supportive and safe environment to develop professionally	Helped normalise difficult experiences	Yes, has reinspired me and encouraged me to continue developing	Yes, enjoyed having the space to debrief and connect	Definitely, I always felt good after a session

7. Does online CS encourage active participation; did you feel comfortable to speak up	Confidence	With our current facilitator, it has been easy to be able to contribute and allowing time for everyone to speak	Easy to speak up and always felt listened to and included.	Direct questions are asked, engagement encouraged	Very comfortable	Really comfortable, supportive space.

Interviews

Participants were invited to attend a one-to-one interview, and six participants volunteered. Of the six, three were from Site A, and three were from Site B, three were experienced Midwifery Group Practice (MGP) midwives and the other three were early career midwives, in their first year of practice. This provided a variety of participants who worked in different models of care with varying levels of experience, improving diversity and richness of data. The duration of the interviews was between 45-60 minutes. The interviews were digitally recorded and transcribed.

Findings

The findings from the analysis of both the open-ended survey responses and interview transcripts resulted in six themes, some with subthemes as detailed in Table 10. These will be described in depth below.

Table 10: Themes and sub-themes

Theme	Sub-Themes
Finding Time and Space	
Having Flexibility	
Valuing Clinical Supervision	Value for teams Professional development
Feeling Safe	
The Online Experience	Benefits of online vs in-person Having the right technology

Finding time and space

Most of the participants surveyed and interviewed mentioned time and/or space in their responses. They discussed difficulties with being able to attend Clinical Supervision due to not having cover of their workload, or simply that their workload was too high to be able to walk away for an hour. The word "space" had a dual meaning: either the physical space required to attend online Clinical Supervision, or the emotional space to take time for reflection. This theme was

recurrent for all participants. The physical space to attend Clinical Supervision was frequently acknowledged to be hard to find, but the mental and emotional space provided by the sessions was also frequently mentioned. One participant said: "I think in terms of how busy our work is, it's almost impossible to find time" (INT01). And one of the survey respondents noted: "Difficult with shifts sometimes but attend when able to" (S3).

Another survey respondent acknowledged the impact short staffing had on her ability to attend: "Can be hard to get off the floor, especially when short staffed" (S4). Another observed that although she needed to create the time, it was worth doing so: "Some sessions needed creative juggling of my workload; however, I find it very beneficial therefore was not in any negative way" (S5). Another explained how she had worked around the difficulties in finding time to attend: "I preferred to attend on a day off" (S10).

The physical space also needed to be private, with no interruptions for the duration of the Clinical Supervision session. This was acknowledged to be difficult in busy public maternity settings, and there was a need for privacy against the possibility of others overhearing the confidential conversations. One participant mentioned: "I'd feel concerned about who was overhearing me or who was listening in if I couldn't find that private space to do it" (INT02). Another participant added: "I found it (hard) trying to find somewhere to be able to do it as well whilst at work" (INT01).

Even though the Clinical Supervision was provided online, participants still wanted to find a quiet space. Being online enabled some participants to join from home: "Finding time and space at work can be hard, so online means we can do it from home sometimes" (INT02). Others found suitable space easier to access in their workplace: "Certainly, possible for us to all just go and find a space. There's Wi-Fi throughout the entire hospital" (INT05), and another saying: "I can just book a clinic room if I'm at work" (INT03).

The field notes show that on one occasion the online Clinical Supervision session was disrupted by a double booking of the room that some participants

were using, which made it difficult in terms of the flow and safety of the session: "The room move was disruptive – it took a few minutes to get back into the group dynamic".

In terms of the mental and emotional 'space' needed, one participant acknowledged the difficulty in changing tempo to sit in the reflective space: "Birth Unit is a high-intensity environment and it's hard to switch gears and take time to think about what's just been happening" (INT04). The emotional space for reflective practice provided by online Clinical Supervision was also acknowledged by this participant: "It was more intimate and gave me, personally, space to reflect in the moment" (INT01).

Having flexibility

Having flexibility was a strong theme, with most interview participants describing this as a helpful aspect of the online Clinical Supervision sessions. It was widely acknowledged that being able to log in to the Clinical Supervision online made it much easier to access, with supervisees potentially joining from different wards or hospitals, as well as outside of the workplace.

The convenience for accessing Clinical Supervision online was also widely noted, with participants discussing the flexibility of being able to join from home, from their car, working around childcare commitments and being able to join from any private space at work: "One of the sessions we had on my phone, sitting in my car, so it's really very portable" (INT03). And again, articulated by this participant; "Online is more flexible, like I can be at home, for me it's personally a better option", and "It's worked really well because it's flexible" (INT02).

The convenience and flexibility were recognised by the survey participants, with one acknowledging the increased access: "It allows for greater access when midwives may be on different wards/hospitals etc. It has been a positive experience having easy access no matter where I'm working" (S1). Improved access was also discussed by other participants, noting their ability to be able to attend from within the work environment, without having to leave the unit: "Access is improved, you are able to step into a room, still on the unit but separate" (INT04).

One participant also articulated that the online platform offered the ability to engage with Clinical Supervision where it may not have been available in-person: "It's giving us access to Clinical Supervision that we didn't have before" (INT05).

Valuing Clinical Supervision

The value of attending Clinical Supervision online was widely recognised by the participants. This theme had two sub-themes: value for teams, and professional development.

Value for teams

There were different reasons for recognising the value of Clinical Supervision for established teams. There was a sense of gaining insight into how team members were feeling, one participant expressed this: "Group sessions are good for the team, it's useful for understanding where others are at" (INT05).

As well as the sessions having value in order to understand how the participants' teams were feeling, the value of having dedicated time with a facilitator to address existing workplace issues was recognised by this participant: "we're [the team] able to sort through a problem that's been there for two years with nobody paying any attention. And that was what came out through the clinical supervision with you. So that was a good thing" (INT06).

The value of the Clinical Supervision sessions for the teams were described by half the interview participants, for example: "I think it is really valuable for teams that weren't working well together. Just to be able to unpack things with a bit of intercession" (INT05). However, one survey respondent posited that there could be limitations, and it's unclear whether her reservations were around Clinical Supervision generally, or specifically when facilitated online. She said: "Things are always a little harder online, but I think in a cohesive team it works well. I could see problems with a team that was in a tough place" (S10).

The field notes, recorded after sessions, showed that during one of the larger group sessions the MGP midwives needed to work through team dynamics. The field notes reflected a sense of discomfort and ultimately the sense of relief when the session progressed to a satisfactory resolution: "It felt uncomfortable to

keep bringing the discussion back to reflection…I felt I helped the team to dig a bit deeper, ensuring that those who were quieter had an opportunity to speak", and later: "In the end it felt united, and the team expressed appreciation for the opportunity to nut out the issue and find solutions"

One survey respondent was articulate in recognising the value for teams generally, but also acknowledging the limitations of Clinical Supervision in a system that is struggling with big issues:

> I think it's great for team building. I'm lucky enough to work in a team that has already worked hard at building trust. BUT clinical supervision is perhaps not so well aligned with current needs - anything short of a full system overhaul is just putting band aids on severed limbs (S10).

Professional development

The participants' responses described the benefit of attending the sessions, to be able to take time to reflect and think about their work. One participant noted: "Helps you to stop for a second and have a little think" (INT05), while another noted: "Gave me some space to reflect in the moment" (INT04).

Clinical Supervision was recognised widely in the data as providing valuable professional development. One survey respondent articulated that she had found the online Clinical Supervision sessions had helped to motivate her: "Has reinspired me and encouraged me to continue developing" (S3). Another acknowledged the safety and support that had provided her with the right environment for professional development: "Has been a very supportive and safe environment to develop professionally" (S9). Another recognised the value of online Clinical Supervision and process of reflective practice aligning well with her professional values: "It has aligned well, facilitating reflective practice and ability to improve professional practices in a safe way" (S1).

Feeling Safe

The survey and interview respondents overwhelmingly described the safety aspect of participating in the online Clinical Supervision sessions. They described that they felt an element of safety and protection by being behind a screen rather

than in the room with their colleagues. The participants also described the sense of safety from the shared experience of being a midwife enabling a level of honesty and being in a supportive environment. At the same time the participants enjoyed the sense of protection of being on screen. One participant found that she felt being online was more personal: "Online is more personal, not being on the spot – the screen provides protection" (INT04). Another expressed that as all participants were midwives, there was an element of openness and shared understanding about their work: "The shared experience of being a midwife allows us all to, really, be open and honest with how things are" (INT03).

Being online for Clinical Supervision gave some participants a sense of safety in being able to share, and that they were in a confidential space, noting that they felt they could be more honest when online, for example: "Always easier to be more honest when not face to face with the other person" (INT05). With this participant noting the added protection afforded by the screen: "I could be more honest online because they were sitting behind the screen" (INT04).

All 11 survey respondents answered the final TFA question, "Does online CS encourage active participation, did you feel comfortable to speak up?" in positive terms. Answers included detail such as: "With our current facilitator, it has been easy to be able to contribute and allowing time for everyone to speak" (S1), and: "Easy to speak up and always felt listened to and included" (S2), and finally: "Yes, very active participation throughout each session" (S6).

Many of the participants expressed that they felt held back when attending a larger group (the largest group in this study comprised seven people) rather than a small group or even one to one. Field notes data suggests this could be because of their awareness of others' needing to speak about current issues or could be that they felt the more talkative members were dominating the group. See Table 5 for participant numbers at sessions provided as part of this study.

One participant noticed that when being part of group sessions, there were colleagues that spoke more than others: "But I think having a larger group is hard because there's always people that want to speak up more than others' (INT01).

Being in a larger group also resulted in some participants feeling very aware of taking up time when speaking about their issues/reflections. They were aware of the needs of others, which meant some were not able to share, with the group what they felt comfortable disclosing. This could be due to the attention of other members of the group, such as: "If there's more people there with you, you tend to not take the floor as much or not talk about it" (INT02).

One-to-one sessions enabled participants to discuss issues they did not feel comfortable with sharing in a group. One participant noted what she would be comfortable discussing in a one-to-one session: "What I might bring up within a group would probably be very different to what I bring up on my own" (INT02). Others similarly articulated that they found value in one-to one Clinical Supervision sessions to discuss some more difficult issues: "Group sessions are good for the team, but I value one to one for those tougher scenarios" (INT05), and "one-to-one gives you the opportunity to discuss things you may not be comfortable with in a group scenario" (INT06).

The online experience

This theme comprises two sub-themes, the benefits of online supervision vs in-person, and having the right technology. The experience of being online for Clinical Supervision was explored in the interviews and surveys, and the field notes also added to the data.

Benefits of online supervision vs in-person

Participants described different aspects of the experience of being online for Clinical Supervision, with many acknowledging that it felt engaging, easy to speak up, and expressing that it was just as good as in-person Clinical Supervision. As mentioned above, the participants found the online platform provided an increased sense of safety. One participant stated that it was a good way to participate in Clinical Supervision: "I think it's a really good alternative and I think it's probably just as acceptable as face to face in my eyes" (INT02). Another recognised that the online sessions had a similar feeling to in-person Clinical Supervision: "You still get the vibe and that's positive" (INT03).

The field notes showed that there were some early issues with becoming accustomed to the online platform in terms of how we communicated and listened: "Today I noticed some talking over each other, but noticed that we are learning to stop, and give each other time to finish".

Whilst the advantages of online Clinical Supervision have been acknowledged, there were also comments that recognised the value of the in-person experience. Participants acknowledged a range of benefits of in-person contact, with one stating that it would be more personable to be in-person with their supervisor: "I think having a real person there makes it more personable" (INT05), and another interviewee noting more generally that humans do value contact with one another: "We humans like that contact. In some ways we're more likely to engage better if someone is sitting right there" (INT02).

It was also noted that being online could lead to more distraction, which could in turn lead to poorer engagement in the Clinical Supervision sessions; "I think having you in the online environment made people a little bit more prone to distraction" (INT05). This participant questioned the value of the contribution from online supervision; "they're not really coming up with meaningful answers because they're not fully engaged with it [online Clinical Supervision]" (INT06). Despite this comment about some participants not being fully engaged, all survey participants stated that they felt largely positive about attending the online Clinical Supervision sessions, and that they felt included and able to fully participate.

Having the right technology

Participants required the correct equipment in order to access the Clinical Supervision sessions. The audiovisual equipment needed to be fit for purpose, meaning that they needed a laptop or computer with a camera and reliable internet connection. Those participants who used a phone to dial in had found that they were not able to be as present or reflective due to the limitations and distractions of the device. One of the responses described this well: "The phone was more of a distraction – with the laptop I was able to sit and just take the time to reflect and engage" (INT04). Others noted that it was harder to be present for the

sessions, and more uncomfortable, when using a mobile phone, for example, two participants said: "[it was a] bit more awkward using the phone" (INT04), and "more distracted and not as present or reflective with the phone" (INT02).

Participants universally acknowledged the ease of access with a computer, particularly with the recent experience with so much work and social engagement pivoting to online delivery with the COVID-19 restrictions, with comments reflecting the change: "everyone's gotten so used to being online for everything - like I did half of my degree online" (INT01). One stated that it was more relaxing and aided reflection when using a laptop: "More ease when you had the actual laptop', laptop is better, more able to relax and reflect" (INT04). However, the connection did occasionally cause issues, and this was reflected in the field notes, with some sessions being impacted by poor connection; "Technical issues today – participant had no visual for the entire session, despite logging out and back in a couple of times". And on another occasion; "Session started late due to connection issues – it took a few minutes for me to connect to group". The field notes also showed that I initially felt very anxious about facilitating the online sessions, with a low tolerance for lateness (not expressed to the groups), and concerned that technical issues such as poor internet connection, or problems accessing technology to join the group might cause difficulties.

Ultimately the few connection issues that were experienced did not appear to impact the experience of the Clinical Supervision sessions provided online. All the survey responses to the TFA question that asked, "How confident did you feel using the technology required to join the CS sessions?" were positive, such as; "Very confident" (S7), and; "it's pretty easy, you just click a link in an email" (S10).

Methodological Triangulation

By using both quantitative and qualitative data collection methods, we were able to strengthen these findings and ensure completeness of our data (Bekhet & Zauszniewski, 2012). The mixed methods approach gave the opportunity to follow up on the quantitative evaluation, using the qualitative questions within the online survey, and further exploration within the interviews. For example, item six in the

CSEQ, "I feel safe sharing clinical issues in supervision sessions" was further explained during interviews with exploration of safety, in terms of what safety meant for the midwives. This is demonstrated in Table 11 below.

Table 111: Triangulation of Themes and TFA

Theme	Sub-themes	TFA/CSEQ Item/s	Average score/response
Finding Time and Space		TFA – Burden/Self-efficacy	Positive
Having Flexibility		TFA – Burden/Opportunity costs	Positive
Valuing Clinical Supervision	Value for teams Professional development	CSEQ item 7 – enabling confidence in practice CSEQ item 10 – practice development TFA – Affective attitude	4.45/5 4.10/5 Positive
Feeling Safe		CSEQ item 1 – confidences respected CSEQ item 6 – safety in sharing CSEQ item 4 – group trust CSEQ item 11 – quality of care	4.65/5 4.30/5 4.75/5 4.39/5
The Online Experience	Benefits of online vs in-person Having the right technology	TFA – self-efficacy TFA – Burden TFA – Affective attitude	Positive Positive Positive

Summary

This chapter has described the findings from the survey and the interviews. The responses to the CSEQ were explained and the process, purpose and impact scores for the online Clinical Supervision were outlined. These scores indicated a positive perception towards the Clinical Supervision provided online.

The thematic analysis identified five main themes, which were: finding time and space, having flexibility, valuing clinical supervision, feeling safe, and the online experience. These themes and their associated sub-themes were illustrated with

quotations from both the qualitative section of the survey (the TFA), the interviews with participants, as well as the inclusions from field notes.

The response from the participants from both the quantitative and qualitative data appears to be largely positive towards the online provision of Clinical Supervision. The quantitative and qualitative responses were triangulated to clearly show the links in the findings. The findings will be further examined to gain additional insights and refer to current literature in the following discussion chapter.

Chapter Four: Discussion

Introduction

It is widely acknowledged that midwives need support within the workplace given the current issues of staffing shortages, work-related stress and burnout in the midwifery workforce across Australia (Borritz et al., 2006; Dahlen et al., 2022; Homer, 2024; Hunter et al., 2019; Matthews et al., 2022). One such support strategy is Clinical Supervision, which provides facilitated reflective practice to help process and understand the emotions and events of individual experiences of midwifery practice (restorative), further develop midwifery practice (formative), and ensure standards of care (normative; Proctor, 1997).

The current study examined the acceptability and experience of Clinical Supervision provided online to midwives in regional NSW. A mixed methods study was undertaken, which included six months of online Clinical Supervision provided to three groups of midwives. Data were collected via online survey tools, including both quantitative and qualitative elements. Further qualitative data were collected via one-to-one interviews, also conducted online. Many of the findings can be related to general Clinical Supervision, whether it be in-person or online.

Overall, the findings support the acceptability of online Clinical Supervision for midwives. Online Clinical Supervision was rated positively by participants in terms of purpose, process, impact, and acceptability. The qualitative data generated five themes: finding time and space, having flexibility, valuing Clinical Supervision, feeling safe, and the online experience. Findings showed that it was difficult for some participants to attend Clinical Supervision regularly despite organisational support, improved accessibility via online delivery, and positive perception of the supervision itself.

This chapter synthesises findings in relation to the relevant literature and is grounded in current midwifery workforce issues. The themes generated from the analysis of the qualitative data from the surveys and interviews are examined alongside the CSEQ findings and are presented here in relation to the broader context of midwifery practice under the subheadings of: (1) benefits of online

Clinical Supervision, (2) barriers to online Clinical Supervision, and (3) requirements for online Clinical Supervision. The strengths and limitations of the study, implications for practice, and suggestions for future research are outlined.

Benefits of online Clinical Supervision

Support and professional development

Participants in the current study described welcoming opportunities for sharing and learning within the online Clinical Supervision sessions. In particular, the new graduate group in this study noted in their interviews that the experience of attending the online sessions enabled them to normalise difficult experiences and reduce isolation. They also recognised it provided a supportive and safe space in which to develop professionally. Provision of a safe group learning environment within Clinical Supervision groups was echoed by Gardner et al. (2021) who also found the connection with, and support from peer groups established in Clinical Supervision, helped to reduce isolation and burnout for regional health workers. Another study, with nursing students and early career nurses, showed that the opportunity to engage in critical reflection, connect with support networks and think objectively about their work helped to challenge the internal critic and build confidence (Driscoll et al., 2019). The current study extended this earlier research by demonstrating similar benefits of Clinical Supervision delivered through the online environment (Gardner et al., 2021; Green & Cappleman, 2023).

Post-covid literature has pointed to attrition of early career midwives (defined as those in the first five years of practice). Given the current average age of midwives in Australia is 45.6 years (ANMF, 2024), attrition is of concern for future staffing when a large percentage of the profession will be lost to retirement. Donnelly (2024) found that early career midwives in Australia described several issues that contributed to intentions to leave their position or profession. These included negative workplace cultures, the emotional and mental impacts of midwifery work, and burnout related to the exhaustion from completing midwifery studies and transitioning to workplaces with poor staffing and little support. Echoed in other studies (Capper et al., 2023; Capper et al., 2022), and a recent literature review showed lack of support (Parry et al, 2024), the reasons early

career midwives consider leaving the professions include a lack of support, dissatisfaction with working conditions, and work-related stress. The authors found that early career midwives wanted to work within continuity of care models such as Midwifery Group Practice (MGP), but few managed to achieve this, often because of structural or procedural constraints (Parry et al., 2024). Providing support, such as online Clinical Supervision as demonstrated in the current study, may be one way to counter some of these issues, and assist with professional development for the early career cohort.

Teamwork

The current study also found recognition of how the online sessions enhanced teamwork. Teamwork, in this instance, is defined as the activity of working together in a group with other people, and particularly when the work is seen as successful (The Cambridge Dictionary, n.d). The team development aspect of Clinical Supervision has been shown to improve communication, increase peer support and understanding, and develop conflict resolution skills for supervisees (Gardner et al., 2021; Hamilton et al., 2023). Teamwork is vital for the safe and effective provision of woman-centred maternity care (Harris et al., 2022). Evidence that good teamwork can improve maternal and newborn outcomes was also demonstrated through a review of maternal and perinatal health networks of care by the World Health Organization (WHO) in collaboration with the United Nations Children's Emergency Fund and the United Nations Fund for Population Activities (WHO, 2024). Conversely, several investigations into adverse outcomes in maternity care in the United Kingdom have identified poor teamwork as a major contributing factor (Harris et al., 2022; Kirkup, 2015; Vize, 2022). In both the qualitative survey data and interviews, study participants described supervision enabling them to communicate more effectively as a team. One of the MGP groups in the current study were able to work through some previously neglected teamwork issues that they brought to the online Clinical Supervision sessions. Another group reported that Clinical Supervision was helpful for them to understand the emotional wellbeing of the team itself.

Maternity units vary in their size, acuity, and in how the units are designed. Some maternity services are disparate across different floors or buildings within the hospital, which may lead to not only physical distance, but possible disconnection between teams. Commonly, a maternity service can comprise an antenatal clinic, an antenatal and postnatal ward, and a birth unit. Bringing together staff from across the service for group Clinical Supervision has the potential to enhance connectivity and inter-departmental relationships (Rothwell et al., 2021). The benefits of collegial relationships between healthcare clinicians can lead to improved communication and trust with poor communication frequently cited as a major issue in investigations into poor clinical outcomes as discussed earlier (Rothwell et al., 2021; Sutherland et al., 2022). Online Clinical Supervision, because of the enhanced accessibility, has the potential to increase connectivity between different wards, departments and hospitals. One of the groups in the current study was brought together from two separate hospitals in the same Local Health District (LHD), and the participants spoke of the reduced sense of isolation from connecting in the online Clinical Supervision space.

Psychological safety

Clinical Supervision aims to provide a psychologically safe space in which to access support and professional sustenance and to develop practice. Psychological safety refers to how safe people feel to speak up, contribute and even challenge (Carter, 2022). The qualitative data from this study indicated that the online environment could provide an *enhanced* sense of psychological safety. Participants commented that being behind the screen afforded significant psychological safety, partly by losing the sense of vulnerability some participants had experienced from their participation in previous in-person group supervision. The feelings of safety provided by the online platform allowed participants the opportunity to be deeply reflective about their work. This is a unique finding of the current study, not been evident in previous Clinical Supervision studies. The safety provided was also echoed in the CSEQ findings in the current study, with high scores for the process subscale, and in particular the two items that directly address safety and respect for sharing confidences (Appendix 3; questions one

and six). The process section of the CSEQ examined whether the participants felt that the Clinical Supervision provided safety, enhanced trust, and whether they felt confident to bring issues for discussion and speak up within the group. The high scores for process indicated that participants found that attending online Clinical Supervision did not compromise their sense of psychological safety. These findings are consistent with other studies which have utilised the CSEQ to evaluate in-person rather than online Clinical Supervision, which found the process section to be the highest scoring of the three sub-sections (Gardner et al., 2021; Green & Cappleman, 2023; Horton et al., 2008).

As previously acknowledged, there is limited literature on online Clinical Supervision, and when mentioned, safety is often identified as a limitation of the online space. The need for additional online-specific training for supervisors intending to work in the online space is mentioned in some of the literature (Martin et al., 2017; Weitz & Moulton-Perkins, 2025). A Romanian study recommends training for supervisors in the use of the online platforms such as Zoom™ and Microsoft Teams™, while also acknowledging the increased competency achieved during the covid-19 pandemic when meetings pivoted to online platforms (Viscu et al., 2023).

There is a lack of evidence in the general literature concerning the enhanced sense of safety provided by the screen that was evident in the current study. However a recent study analysing 549 comments from a LinkedIn discussion board found that meeting participants felt more comfortable and less anxious in virtual meetings, particularly due to the perceived psychological safety of being behind a screen. The authors discuss how reduced social pressure, control over self-presentation, and physical separation contribute to this sense of safety (Karl et al., 2022)

Barriers to online Clinical Supervision

Time was taken in the introductory group sessions with potential participants to explain Clinical Supervision and build trust, but of the 19 midwives initially invited to be part of the study, there were four midwives who declined to

attend the sessions. It was not known what the reasons for declining participation were, but these may have been related to aspects of safety, trust or a misinterpretation of the purpose of Clinical Supervision. The term Clinical Supervision can be misunderstood to mean supervision of clinical skills, managerial surveillance, discipline or performance management (Masamha et al., 2022; White & Winstanley, 2021). These aspects of Clinical Supervision align more with "normative" than "restorative" or "formative" functions (Proctor, 1997). This can be a barrier to many nurses, midwives and other health professionals who perceive that it is not a safe, reflective or confidential space and therefore can be ambivalent to attend (Buus et al., 2018; Masamha et al., 2022).

In the current study, an explanation about the reflective focus was provided to participants to dispel myths or misconceptions about the nature of Clinical Supervision. However, data was not collected from four midwives who chose not to attend any of the Clinical Supervision sessions offered and we are therefore unable to ascertain their reasons for reluctance. A study by Buus et al. (2018) recognised two main groups who did not engage with regular supervision: those who valued it but for whom attendance costs were too great a personal effort due to shift work hours, work or family commitments; and those that deliberately chose to reject supervision support (Buus et al., 2018). The reasons given within Buus et al (2018) for rejecting supervision based on their perceptions of what Clinical Supervision involves. For others when they had attended it had been a negative experience, too uncomfortable or exposing in the session, or a lack of trust amongst the group. Others felt that it was a waste of time, that nothing would change as a result of attending, and some believed it was a managerial intervention (Buus, 2018).

To engage in Clinical Supervision, whether in-person or online, finding time and space to attend are vital. Attendance within the current study ranged from 17% - 100% of midwives at each of the monthly sessions at the three sites. Some of the participants were theoretically supported to attend Clinical Supervision by their managers, but in practical terms were not offered any relief from clinical work to attend, the onus being on the individual to create time for attendance. For

others in the study, good managerial support with time and space being facilitated had a positive impact on attendance, with the most consistent attendance from the group that had pragmatic managerial support to attend following their team meeting. Understanding the value of Clinical Supervision is different from tangibly supporting staff attendance. For example, Driscoll (2019) found that while some organisations recognised the importance of providing Clinical Supervision, they did not place the same value on staff attending as they did on focussing on their clinical work.

The group of early career midwives in the current study stated there was no provision of relief by other clinical staff to enable them to easily step away from their work to attend the Clinical Supervision sessions. Some of the midwives expressed guilt at leaving the clinical space to attend or having a sense of letting the team down which prevented them from attending some sessions, which was expressed either during the session, or as the reason for non-attendance. Finding time for Clinical Supervision has been acknowledged as a juggling act, and healthcare staff can also have difficulties with finding time for other non-clinical aspects of their work. For example, King et al. (2020) recognised that there was not enough non-clinical duty time available for most staff to attend to tasks such as student support and education. They found that the health service size and organisational approach to Clinical Supervision had an influence on whether staff felt supported to attend. This was also affected by the attitude of the organisation towards Clinical Supervision and the discipline, with allied health and speech pathology staff being more likely to access the sessions than nursing staff (King et al., 2020). This is evident in the findings from the current study, where attendance was, in some instances, enhanced by practical managerial support, such as the provision of time and a private space. In one setting within this study the Clinical Midwifery Educator gave up her office for the midwives to use for the sessions, as well as striving to ensure a reasonable clinical load to enable attendance.

In the current study, for one group (Site B) the clinical managers were reportedly in favour of staff attending the online Clinical Supervision sessions, but there was little support available in terms of practical measures to assist midwives

to attend, such as relief from clinical duties. Some of the midwives chose to request days off to ensure attendance, which they had the flexibility to do through the online provision. This demonstrated the value that the midwives placed on their attendance at the session, and the impact of practical support or lack thereof. That said, ideally the Clinical Supervision should have been incorporated into their workday. Another group (Site A) was not only encouraged to attend, but the Clinical Supervision session was intentionally scheduled at a regular meeting time to ensure the midwives were able to attend, as well as a private space for online attendance.

Clinical Supervision can be undermined when staff think there is a real or perceived lack of support at an organisational level, which has been linked to a reduction in attendance and effectiveness (Doody et al., 2024; Driscoll et al., 2019; Reschke et al., 2021; White & Winstanley, 2009). Middle management could either see Clinical Supervision as part of nursing practice or an added extra, and how they perceived its value had a direct impact on universal acceptance of the need for staff to attend the sessions. A landmark study conducted with mental health nurses in Australia, found that those clinicians who were the busiest, most stressed and likely to need self-care often were unable to find space to attend, or did not prioritise it as necessary for their wellbeing (White & Winstanley, 2009). The authors found that when Clinical Supervision was seen as an additional activity rather than part of the working day, it appeared to stretch staff resources and create tension within the workplace. It was also noted that whilst many senior managers supported, in theory, the implementation of regular Clinical Supervision, there was frustration with a lack of support from clinical managers (White & Winstanley, 2009).

In terms of more personal barriers, some of the midwives in the current study reported difficulty in 'switching gears' from being the care provider to attending to self-care or any supportive strategy. A recent study described having self-awareness as a protective factor that helped to build resilience and supported colleagues to seek support for themselves (Hunter & Warren, 2022). The authors also acknowledged the intensely emotional work that midwives undertook in their

profession, and that it can be hard to seek support and care or even acknowledge the impact of this work. The authors recognised the value of sharing and reflection in building individual resilience. For many midwives the default coping mechanisms included exercise, alcohol consumption and social support from friends and colleagues (Hunter & Warren, 2014). Self-care or supportive strategies for health care staff have been widely implemented and recognised as important in recent years, with many LHDs in NSW offering some form of self-care to their staff (e.g., Stability, Encompassing, Endurance and Direction (SEED); Mackay et al., 2021); Gathering of Kindness (Health, 2024a)). The existence of these, and other locally developed self-care programs, demonstrate the recognition of the value of staff wellbeing within health organisations. What we have not seen yet is a co-ordinated approach to facilitating regular attendance to any self-care strategy, whether online or in-person, by providing quarantined time by releasing staff from clinical duties on a regular basis, which is necessary for sustained Clinical Supervision and many of the other strategies mentioned in order for them to have an impact. Online Clinical Supervision should be considered to fill this gap.

Further barriers may exist in terms of pre-existing attitudes towards online compared with in-person supervision. For example, Watters and Northey (2020) reviewed the literature surrounding online supervision for marriage and family therapists and acknowledged the reluctance of some in the profession to embrace online Clinical Supervision, despite the recognised benefits. This was felt to be due to the so-called "old guard" of regulators and accreditation organisations that may consider online Clinical Supervision inferior and unsuitable to their professions (Watters & Northey Jr, 2020). Their study was conducted in the United States of America, so this view may or may not be generalisable to Australia. Australia has a position statement that supports Clinical Supervision and promotes the positionality of Clinical Supervision within Australia for nurses and midwives (ACM ACN and ACMHN, 2024). The position statement does not specify that Clinical Supervision can be provided online but does acknowledge that it should be actively promoted and provided by all workplaces and recognises many of the proven benefits for health care workers. The Australian Capital Territory (ACT) has a

Clinical Supervision framework, and personal communication reveals that the ACT government has significantly invested in training supervisors across their nursing, midwifery, and allied health workforce (ACT Health, 2023). The ACT Health document makes no reference to the provision of online Clinical Supervision.

Requirements for online Clinical Supervision

Prioritising space and time for professional development

It is recognised that midwives need time and space to debrief and reflect on their work (Doherty & O'Brien, 2022; Hunter & Warren, 2022). Finding time and space for Clinical Supervision, as a form of professional development, emerged as a significant theme from the qualitative data of this study. The surveys and the interviews showed that both the physical and the reflective space were equally important. Participants commented that effort and forward planning was needed to attend supervision. Attendance during working hours was heavily reliant on the participants' roster and workloads being favourable. Many participants reported that they found attending online Clinical Supervision more accessible than in-person, as they did not have to physically attend a venue and could also attend in their own time rather than within work hours. These findings again emphasise benefits to attending supervision online compared with in-person (Featherbe, 2023; Gardner et al., 2021; Love et al., 2017; Martin et al., 2018; Martin et al., 2022; Rothwell et al., 2021; Snowdon et al., 2020).

Physical space required for participating in online Clinical Supervision was recognised by the participants in the current study as vital. Some participants had access to suitable clinic rooms, where there was a table and chairs, reliable Wi-Fi, and privacy, whereas for others it was a challenge to find a private space where they would not be overheard. A confidential space, without interruptions has been identified as one of the crucial supports needed for Clinical Supervision (Doody et al., 2024; Snowdon et al., 2020). As well as struggling to find the right space, sometimes participants did not have access to optimal equipment, such as a computer with a camera. On occasion, sessions were interrupted by someone needing to access clinical equipment in the room or retrieve their lunch that was in the fridge within the chosen room. These interruptions led to disruption to the flow

of the session and potentially affected the psychological safety of all group members. This was not directly raised by any of the participants in the data, but was noted in the field notes to have caused a break in the flow of the session. In this study, midwives who did not have reliable access to a suitable space either chose to join from home (choosing to request a day off if needed) or used their phone to join from a room within their clinical space. It was noted that phones were less than ideal, but were acceptable to some participants, if a laptop was unavailable. A couple of participants shared that they had no problems or issues with joining from their phone in their car, whereas another midwife shared that they had to use their phone when no computer with a camera was available. They were able to join but the phone had slipped down or fallen over a couple of times, distracting them from the session. Other participants also noted that the phone was distracting or hampered the reflective process for them.

Being able to *stop and think* in Clinical Supervision sessions was recognised and valued by some of the midwives in the current study. Previous research has identified the importance of staff having the opportunity to step out of the clinical space and be given time to reflect in a safe space, particularly when the clinical work was difficult (Green & Cappleman, 2023; Lees, 2017). The current study confirmed these findings. In the context of stressful and emotionally taxing work carried out in the midwifery field, this opportunity to step away from practice and utilise facilitated online reflection to process emotional responses to work was seen as supportive by the midwives in the current study.

The current study was well-supported by the senior midwifery managers of the participating LHDs. The findings demonstrate that attendance at Clinical Supervision is improved by managerial support and midwives' increased autonomy in scheduling sessions. In our study, participants were able to choose to attend the online clinical supervision from home, their car, or from within the hospital, depending on their preference and workload. These options are not all available with in-person sessions. However, it is noted that one of our groups were employed in an MGP model of care and not all midwives work this way.   MGP is a model of care where midwives, as lead care providers, have more control over their

schedule and work across the full scope of practice of midwifery – through women's pregnancies, labour, birth and the postnatal period (Cull, 2018; Hewitt et al., 2022). Correspondingly, in the current study, early career midwives working shifts in the standard maternity care model found it more difficult to attend the Clinical Supervision sessions provided, although some did choose to attend on their day off, from home, which was possible due to the flexibility of the online platform. Management and leadership support of Clinical Supervision has been found to have an influence on staff participation, specifically that a lack of organisational and management support results in poor attendance, whereas support from empowering leadership has been shown to increase attendance (Howard & Peirson, 2024 {Rothwell, 2021 #261).

Skilled Facilitation

The current study showed that the facilitator was instrumental in providing safe and acceptable Clinical Supervision online, with participants referring to the guidance provided by their facilitator. Research has identified that a lack of supervisor skills and training is seen as a significant barrier to effective supervision, and an experienced and skilled facilitator is associated with improved attendance and participation (Rothwell et al., 2021; Snowdon et al., 2020). Providing a safe and supportive environment for staff to reflect and develop is a crucial component of successful Clinical Supervision (Driscoll et al., 2019; Hamilton et al., 2023; Reschke et al., 2021; Schumann et al., 2020). Skilled facilitation of a group promotes a safe and enabling environment in which staff can let off steam, engage in critical reflection and support each other (Driscoll et al., 2019; Hamilton et al., 2023). Much of the literature that discusses the key attributes of an effective Clinical Supervisor does not describe professional development requirements for supervisors (Rothwell et al., 2021). The clinical supervisor in this study was an experienced facilitator who had attended eight days of professional supervisor training during a 12-month period, followed by four further days of advanced supervisor skills training. For comparison, a Clinical Supervisor approved by the Psychology Board of Australia is required to attend 10-hours of online training, a two-day workshop, and then submit an assessed

videotaped demonstration of supervision (Psychology Board of Australia, 2024). Clinical Supervisor training on the NSW Health 'My Health Learning' professional development site comprises 7.5-hours, with an additional option for intermediate training of a further 8-hours (HETI, 2024). The recommendation is for supervisors to have attended training in the application of reflective models and in management of group dynamics (Key et al., 2019). There is also a recommendation that for those intending to facilitate Clinical Supervision online, there should be specific training, but their report does not detail what that training should entail other than in the use of the technology (Soheilian et al., 2023).

Evidence suggests that Clinical Supervision is crucial for students transitioning to practice as new graduates, and that the experience of this transition affects retention (King et al., 2020). Currently midwifery degrees (whose content is overseen by the Australian Nursing and Midwifery Accreditation Council (ANMAC) have a strong focus on reflective practice. The University of Newcastle offers online Clinical Supervision to their Bachelor of Midwifery students on a regular basis (personal communication January 28, 2025). Following graduation, many workplaces do not routinely provide this support.

Limitations of Clinical Supervision

Well-documented issues in the maternity work environment which have an impact on midwives' wellbeing include high workloads, high acuity, short staffing, high staff turnover and poor skill mix (Cull et al., 2020; Matthews et al., 2022; Matthews et al., 2024; Rost et al., 2024). Midwives sometimes feel that they have to work with guidelines and policies which can be perceived to be system-centric or obstetric-led rather than woman-centred or working within a midwifery philosophy (McFarland et al., 2020; Rost et al., 2024). This can lead to professional dissonance working in hospital systems in which there is a significant gap between the optimal, woman-centred model of care which they have learnt about in their midwifery education, and the actual, system-centred practice of midwifery which they encounter in the hospital (McFarland et al., 2020; Rost et al., 2024). To mitigate this, a study by a well-known midwifery advocate found that

midwives have used "stealth" to work around the policies and find ways to work within the dominant culture (Kirkham, 1999). Twenty-six years later, stealth may still be the case to some extent, but it appears that midwives remain disillusioned by the medical dominance of hospital maternity services and consequently their work practises (Catling & Rossiter, 2020; Matthews et al., 2022).

Within this context, it should be acknowledged that while Clinical Supervision, delivered online or in-person, can provide a safe space to let off steam, to reflect on workplace issues and help midwives to find ways to work within the challenges of the system, it cannot directly address the problematic issues of high workloads and acuity, short staffing, high staff turnover and poor skill mix, as recognised by the recent Midwifery Futures document (Homer, 2024). One quote from the current study metaphorically questions the depth of support needed: "Anything short of a major system overhaul is just putting Band-Aids on severed limbs". This comment recognises that in order to support the maternity system and midwives, much more was necessary from an organisational perspective. This was not commonly expressed by participants, but it clearly acknowledges the limitations of what Clinical Supervision can provide. Clinical Supervision may not suit all midwives, or all situations that warrant discussion.

The lowest scoring section on the CSEQ in this study was the impact subscale. Impact, in this context, refers to the supervisee's perception of how the sessions create change in their practice, or sense of wellbeing at work (Horton et al., 2008). The lowest scoring item being "Clinical Supervision has helped me to deal with any stresses at work I may have had". This section was also the lowest scoring section in other studies, which were all concerned with in-person provision rather than online (Gardner et al., 2021; Horton et al., 2008). There may be a number of reasons why the impact section was the lowest scoring. For example, midwives often feel that they have very little control over their work, which can impact their stress levels and sense of wellbeing at work (Cull et al., 2020; Matthews et al., 2022). In reality, midwives often feel a lack of autonomy and recognition, particularly in highly medicalised work environments, often found in high-income countries (Carvajal et al., 2024; Froneman et al., 2019; Rost et al.,

2024; Zolkefli et al., 2020). Studies examining the Status, Certainty. Autonomy, Relatedness and Fairness (SCARF) model of organisational change management in health, show that not only is autonomy recognised as crucial across different professions, but *certainty* is also important (Rock, 2008). Certainty enables staff to experience stability in their role, and this can enhance job performance and an individual's commitment to their employing organisation (Savaneviciene & Girdauskiene, 2020).

The provision of effective and compassionate care relies on the health and wellbeing of the health professionals delivering this care. It is therefore vital to find strategies to support staff to ensure they can cope with the demands of their profession. This means that organisations have a duty to help avoid staff experiencing compassion fatigue, stress, and burnout (Featherbe, 2023; West et al., 2020). There is a need for varied, sustained, and coordinated approaches to professional support (Gardner et al., 2021). One local support strategy was the NSW Health Mentoring in Midwifery (MiM) project – a project funded by the Ministry of Health for two years to implement professional development and support for midwives to provide mentoring to students and new graduate midwives. Based on the strategies successfully introduced in the Exploring and Developing Student Midwives' Experiences (ESME study) (Dewar et al., 2020), the MiM project has yet to be formally evaluated. Additionally, the project has now been completed, leaving many LHDs to self-fund the continuance of a similar program, or cease any mentoring support that was put in place.

Organisational supports beyond Clinical Supervision include informal and more formal strategies such as peer support, Schwartz rounds, hot and cold debriefing and Employee Assistance Programs (EAP). Peer support can be informal support from one colleague to another, or organised peer supervision groups (Tulleners et al., 2023). These have been shown to provide a safe space to share, reflect and build teams amongst midwives, nurses and other health professionals (McCarthy et al., 2021; Tulleners et al., 2023). Schwartz rounds are a regular forum for all healthcare staff (clinical and non-clinical) to come together and discuss the emotional and social aspects of their work. They have been well documented to

show efficacy in enhancing staff wellbeing, combatting compassion fatigue and improving the provision of compassionate care (Flanagan et al., 2020; Maben et al., 2021; Thompson, 2013). Hot and cold debriefing is where staff are given an opportunity to explore clinical emergencies immediately after the event (hot) and/or a few days or weeks after the event (cold). These debriefs can assist staff in processing and learning from critical clinical incidents (Gilmartin et al., 2020; Zinns et al., 2020). EAP provides employees and their immediate families access to confidential counselling, as well as a coaching and wellbeing service, but is only for short term support (Health Education and Training Institute, 2013). However, apart from EAPs, the availability of these supports is sporadic and not widespread. Furthermore, the issue with implementation and sustainability of such programmes is the provision of protected time for staff to be released from clinical duties to attend. Managerial support, as discussed earlier, is crucial for staff to be able to take advantage of any such support being offered.

Strengths and limitations of this study

A strength of this study was that the online Clinical Supervision sessions were offered monthly over a six-month period. This time period and frequency of Clinical Supervision sessions has previously been shown to make a difference in stress and burnout measures in Wallbank (2010) that included midwives. However, it was also a limitation as for some participants six months may have not been long enough to provide a safety net to share and engage in deep reflection, and particularly for those who attended less sessions. Ideally Clinical Supervision would be a regular activity within the workplace that should be sustained over time, as an ongoing and indefinite support (Rothwell et al., 2021). In the current study it was unknown whether the benefits were able to be sustained following the completion of the six months of online Clinical Supervision provided. It was also outside the scope of this study to examine any effects on staff working with the participants but who had not themselves attended any of the online sessions.

A further strength of this study was the significant level of comfort with the online space in terms of safety, which is unique among studies of online Clinical Supervision. Many of the midwives found that being online felt safe, and that safety afforded them the opportunity to be deeply reflective about their work. An ability to engage in meaningful reflection about work related issues contributes to an increase in resilience and decrease in burnout and stress (Driscoll et al., 2019; Francis & Bulman, 2019).

For one of the groups, the midwives were strongly encouraged to attend by their manager, with the session scheduled in conjunction with their regular team meeting. While the regular attendance was appreciated by the facilitator, this method of recruitment may have resulted in some midwives attending involuntarily simply because they were attending their team meeting. Despite this, it was clear to all participants that attending the Clinical Supervision sessions was voluntary and that they could leave if they wished. It is acknowledged that voluntary attendance is preferable, to enhance group cohesion and alliance with the supervisor (Pollock et al., 2017; Reschke et al., 2021).

The two different cohorts were made up of early career midwives and group practice midwives. Arguably neither of these groups necessarily represent the typical core clinical staff members of midwifery services. This is a limitation of this study as the results may have been skewed by the attendance of autonomous practitioners and passionate early career midwives in their first year of practice. Further studies could include core midwifery staff that may lead to more varied results.

As both researcher and interviewer for the participants, asking about the online Clinical Supervision I had facilitated for them, the participants could have felt hindered in being entirely honest about their experiences of online Clinical Supervision. This could have been particularly relevant where they may have had negative issues they might have wanted to raise. To reduce this risk, a frank conversation was had at the start of each interview to ensure that they knew that their honesty was useful to the study, and that they should be open and honest

about their experiences. The mixed methods approach also allowed data to be captured through anonymous survey completion, where any negativity could be easily expressed, and would have been reflected in the results of the quantitative CSEQ results and the qualitative TFA responses. Reflexivity was crucial to this part of the data collection and analysis, to maintain awareness of personal bias.

This study was limited by nature of being part of a research master's degree, and as such data collection was limited to the midwives who attended the Clinical Supervision sessions.

Summary

This chapter has synthesised the key findings of the current study in relation to current literature; that online Clinical Supervision is as acceptable as in-person, and better for psychological safety. It was found that many personal and organisational barriers impacted attendance at supervision sessions, and requirements for successful online Clinical Supervision were identified. The major themes identified within the findings were explored and discussed to find further meaning and relevance.

The next section will discuss the implications for practice, areas for further study, and summarise the study. Finally, a reflection on my role as researcher, and its challenges, has been stated in relation to my role as facilitator of all the online Clinical Supervision sessions in the current study.

Chapter Five: Implications for practice, and for future study

This section will include considerations for future research and consider recommendations for online Clinical Supervision. Information identified from this study and the literature will be shared on how to set up online Clinical Supervision for optimal engagement and outcomes.

Organisational Commitment

Time

One of the Midwifery Group Practice teams (MGP) in this study were supported to attend the Clinical Supervision sessions immediately following their regular team meeting, which meant that group attendance was reliable with six attendees each month. This enhanced attendance, with the participants feeling supported and safe to attend from a clinical viewpoint. If health services want to ensure that staff are able to attend support strategies such as Clinical Supervision, real practical support needs to be in place. Rostering to enable attendance at a regular group or individual session and protected time away from the clinical space are crucial. As some people made the choice, in this study, to attend on their days off, it could be recommended that people are provided with the option to attend in their own time (from home if they wish) and to claim the time back. This would enable them to be paid for attendance which would demonstrate organisational support and value for attendance at Clinical Supervision.

Technology

Another important consideration for attendance at online Clinical Supervision sessions is the availability of the right technology; midwives need access to an internet enabled device of their preference with a camera and a stable internet connection.

Privacy and Space

The physical space required to attend should also be considered. Attendance at Clinical Supervision, whether online or in-person requires an appropriate physical space, this space should be private and without

interruptions, where staff will not be overheard. In order for Clinical Supervision to be integrated into the workday, appropriate space needs to be provided to enable staff to attend online sessions in a safe and private room. This should include the opportunity to attend one-to-one sessions occasionally, when needed.

Financial Commitment

Many health organisations offer additional support strategies to staff and show willingness to provide support. A financial commitment to this would include providing training to staff to become Clinical Supervisors, and adequate rostering/staffing to enable staff to attend regular sessions.

Mandatory training and Professional Development

As with some health professions, to ensure the sustainability of Clinical Supervision programmes, building Clinical Supervision attendance into mandatory professional development requirements would be beneficial. This would require significant commitment from government agencies to build capacity and financial support.

Group vs individual Clinical Supervision

Findings from this study and from the literature identify that there are strong benefits for healthcare workers attending group Clinical Supervision, whether this is offered in-person or online. The group attendees benefit from a shared understanding and experience and can strengthen teams and interprofessional relationships (Gardner et al., 2021). Participants in the current study also spoke of the benefits of individual Clinical Supervision provided online, on the occasions when poor attendance resulted in an unplanned individual session. The literature echoes this, with recommendations for a combination of group and individual sessions for best results (O'Neill et al., 2022). A recent study from the UK found that attendance at group Clinical Supervision and psychologically informed debriefs as well as one-to-one sessions were important in improving midwives' emotional wellbeing and thus reducing the risk of burnout (Archibald et al., 2025). Group size is also important to consider, with the ideal being generally accepted as approximately four to six supervisees (O'Neill et al., 2022).

Facilitator skills

For optimum group/individual facilitation, the supervisors should be trained, ideally from a similar clinical background, or at least have a good understanding of the common issues (Rothwell et al., 2021; Snowdon et al., 2020). The midwives in the current study valued the inside knowledge of their profession demonstrated by the facilitator. For online facilitation, the supervisor should be familiar and competent with the chosen technology. Skills valued by participants in their facilitators include good listening skills, clinical competence, cultural competence, and ability to give and receive feedback (Rothwell et al., 2021). This competence includes the ability to manage whatever emotions come into the room; the supervisees need to know that they will be provided with psychological safety (Reschke et al., 2021). The training of Clinical Supervisors varies from profession to profession, and across different health jurisdictions. A lack of robust training and support for supervisors can lead to ineffective supervision at best, and cause harm in some cases, where emotions and professional issues are not dealt with appropriately or adequately. Lack of supervisor competence and skills has been recognised as one of the barriers to effective supervision (Rothwell et al., 2021). It should be noted that it is crucial that supervisors attend their own supervision sessions to have the opportunity to discuss their own supervision experiences and issues (Martin, 2018; Viscu, 2023).

Group set-up

Findings from other studies have found benefits for participants who have a previously established relationship with their supervisor prior to commencing online group Clinical Supervision (Chaisty & Cunningham, 2021). Whilst it may be feasible to facilitate this in-person when the supervisor works in the same locality, for more remote locations it may be more practical to attend one or two individual online sessions prior to the commencement of the group. This would allow for the building of trust and ensure a solid understanding of what Clinical Supervision is, the process and conduct of the sessions.

In terms of the optimal set-up for an online Clinical Supervision group, from the experience in this study, the following recommendations are made. Ideally all

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group members would use an individual device, to provide opportunity for equitable participation, observation of non-verbal cues and body language and to ensure no sideways conversations within the room (as can happen when sharing a space and screen). If space is limited, the recommendation from this study would be for no more than two group members to be sharing a single space and screen.

Setting up for optimal engagement and experience should involve attention to creating the group culture, which should be done from the beginning. It is good practice to spend time working out the ways of working and goals for each session, to establish the ground rules of engagement. In this process, preferences should be discussed around the mandatory use of cameras, and whether sideways chat is encouraged or permitted, whether group members all join from their own space or a shared space, and how to manage online etiquette. Having clear *group rules* and goals from the outset has been seen to be beneficial (Reschke et al., 2021).

Future research

In the current study it was unknown whether the effects shown in the results were able to be sustained following the completion of the six months of Clinical Supervision provided, and this follow-up was out of the scope of a master's research degree. A long-term follow-up study examining the impact of regular online and closed group (where the same supervisees are included at each session) Clinical Supervision for midwives would add value, providing evidence for provision of this support strategy. Potentially a study examining the reasons for non-attendance at Clinical Supervision, whether in-person or online, would provide additional information to assist in shaping the provision of support to midwives. Further research could also examine the effects on colleagues of those who attend Clinical Supervision, to evaluate any vicarious benefits, such as improved communication or morale. Provision of online Clinical Supervision to core midwifery staff, as opposed to MGP and early career midwives, with a focus on discovering strategies that support staff to attend sessions would be beneficial. It would also be of interest to explore the link between online supervision and reflective practice, and whether online provision of Clinical Supervision has a positive impact on professional midwifery practice.

Chapter Six: Conclusions

This study set out to examine the acceptability and experience of Clinical Supervision provided online to midwives. The background to this provided information on the current global state of the midwifery workforce, with a closer examination of the local Australian midwifery workforce, including student midwives and those in the early years of practice. The issues and concerns around the wellbeing of the workforce were described, with a focus on workloads, compassion fatigue, moral distress and burnout.

The literature review outlined the search strategy employed for this study and looked in detail at the seven studies found through this search strategy. None of the included studies had any midwives as participants, however the themes were considered to be common across health professions, and online Clinical Supervision was common to all the studies. The main themes that were identified in the literature were: the benefits and the challenges of videoconferencing for Clinical Supervision, non-verbal cues, access to technology and facilitator skills.

The recruitment of participants and ethical considerations were explained, the mixed methods approach was outlined, with an examination of the Clinical Supervision Evaluation Questionnaire (CSEQ), a validated tool, and why it was thought to be the most appropriate quantitative measure for this study. The Theoretical Framework of Acceptability (TFA) and how it was adapted for the qualitative section of the online survey was discussed. The use of one-to-one interviews and triangulation were detailed, and thematic analysis of the qualitative data from the survey and interviews described. The quantitative and qualitative findings were outlined in the results chapter, with the identification of five main themes: 1) Finding time and space; 2) having flexibility; 3) valuing Clinical Supervision; 4) feeling safe; and 5) the online experience. The findings indicated a largely positive response to Clinical Supervision provided online to midwives.

These results and themes were further scrutinised in the discussion section, with a thorough exploration of the relevant current literature. Finally,

recommendations for practice, with a consideration of future research were included.

Chapter Seven: Reflections from Clinical Supervision

This study provided me with an opportunity to provide much needed support to midwives in two regional areas. I had recently moved out of a clinical role and was eager to be working to drive cultural change where I had witnessed and experienced poor culture and staff dissatisfaction.

The dual role of Clinical Supervisor and researcher was challenging. Recruiting the midwife participants necessarily had to be organised through liaising with management, which resulted in the development of a relationship with the manager prior to being able to contact the midwives. It was important that the midwives did not feel that their privacy was compromised, or that there was managerial oversight of the Clinical Supervision. At the same time, the managers' support was crucial to the implementation of the Clinical Supervision sessions.

My role as an experienced midwife gave me the privilege of insider status, with the midwives aware that their supervisor (me) had experience and knowledge of the world they described and reflected on in the sessions. I needed to be aware of any bias and expectations with the subject matter (Maso et al., 2003; Steen & Roberts, 2011). This was particularly pertinent with the Illawarra Shoalhaven Local Health District (ISLHD) midwives, where an additional level of insider status was afforded by my position within the LHD at the time of the study. It should be noted that I had been previously employed within the same LHD as the midwives but at no point held roles such as the line manager for the midwives within this group. The Midwifery Group Practice (MGP) groups appreciated my insider knowledge of their model of care, and the challenges and joys of their work, and it appeared to be beneficial to the sessions to have that commonality and level of understanding. This commonality also provided an additional challenge for me, as supervisor. Whilst it was helpful to have the midwifery knowledge and experience, it was also sometimes quite hard to not be 'seduced by the content'. This phrase is a term used in the Role Development training I attended and refers to being drawn in to the details of the story which can lead to lack of focus on the purpose and reflective process of the session. I knew the staff, the dynamics and the

challenges only too well. It is important, as a supervisor, to remain *outside* the story, not be drawn in and become emotionally involved. There was always part of me that wanted to be outraged, saddened or horrified, and to ask, "and then what happened?" I had to remind myself occasionally of the role I was in, and to maintain the supervisor persona, to ask the appropriate questions and to facilitate the reflective process.

Clinical Supervision always opens the possibility of encountering difficult subject matter, and strong emotional responses from the supervisees. My training as a Clinical Supervisor had addressed this, and my experience as a Clinical Supervisor and as a midwife had prepared me well for any such occurrence. What I had not anticipated was the discomfort and distress I felt when the early career midwives disclosed their stories of bullying and the impact of poor workplace culture within my own workplace on their wellbeing. It took some effort on my part to maintain my composure as supervisor and hold the space for reflection and professional development for the supervisee/s. To protect my own wellbeing and ensure that I was able to grow and develop as a supervisor, it was important that I was attending regular Clinical Supervision sessions with my own supervisor. Completing the field notes journal also afforded a period of reflection, encouraging consideration of alternative strategies. Attending personal self-care was also something that helped to maintain my equilibrium, these included activities such as yoga, time with friends and family and time spent alone. Attending my own Clinical Supervision during this time was essential, giving the opportunity to share challenges and ideas with a more experienced supervisor. It also enabled greater awareness of my responses and reactions within the groups.

Occasionally a supervisee became distressed during a group. This was generally something that was managed relatively easily with compassion and some space. Whenever this occurred, I would check in on the supervisee towards the end of the group and suggest that they could stay online if they wished to chat at the end of the group session. I would then assess whether they required further support, and we would work out together what that might be – offering EAP, GP or other formal supports if required. On one occasion, the supervisee stayed online,

after the group session finished, for about 30 minutes, until they felt able to return to their clinical duties. When I felt it necessary or appropriate, I would ask if the supervisee would like me to contact them the next day or beyond to check in and discuss external supports. I would not seek to do this without the consent of the individual concerned. I would also regularly offer my details with an open invitation to contact me if the need arose between sessions.

Facilitating the group sessions was challenging at the start. I had been trained in in-person techniques, learning how to use props during sessions to enhance the reflective process. Providing sessions online made these techniques harder to utilise. I needed to think about how these techniques could be altered to be used with pen and paper, or to use more verbal techniques. Over time I became more adept and fluent with being creative about how to utilise and adapt the techniques I had been trained in.

With one of the groups, it was apparent that some of the supervisees were less enthusiastic about attending, despite having completed the consent form and agreeing to take part in the study. Their presence in the group was less engaged from time to time. To a degree I am always happy to ensure people feel comfortable to be present and not take part, but it can be harder online to ensure that this occurs. To mediate this, I would ask them occasionally if they wished to add anything, giving them an opportunity to participate if they wished.

Conducting the interviews presented me with a new set of challenges, with the awareness that I was interviewing the midwives about the Clinical Supervision that I (the researcher) had provided. At the commencement of each interview, I spoke of the purpose of the interview and discussed the need for honesty and openness. I reiterated that any negative feedback would be welcomed, and no offence would be taken. Any negative feedback was accepted and explored, and the temptation to take any negative feedback on a personal level was resisted. This is in line with recommendations from the literature (Olesen, 2011).

During the interview process, due to having been present in all the sessions provided, there were occasions when questions needed to be expanded or

answers further explored, despite already being aware of the likely answer. I had to make a conscious choice to continue to explore, when the experience of having been present in the group gave me inside information. It was important to remember that the information I had was my experience of the group, not necessarily that of the interviewee.

This study has provided me with valuable experience and insights into the worlds of midwifery and online Clinical Supervision. It has been a labour of love with many occasions when it all felt too hard. I couldn't have finished this work without the dedicated support of my supervisors, both my university supervisors and my own Clinical Supervisor. Clinical Supervision provides the mental and emotional space to take a more objective view of your work, and to keep bringing your best self to work. This study has both exhausted and sustained me and has certainly deepened my understanding of how to support midwives in their vital work.

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Appendices

Appendix 1: Participant Information Statement (attached to online survey)

Participant Information Statement

| *Midwives' perceptions of online Clinical Supervision* |
| *Co-ordinating Investigator: Associate Professor Christine Catling*
Study contact person: Helen Donovan
Co-Investigator: Associate Professor Allison Cummins |
| |

Introduction

You are invited to take part in a research study investigating online Clinical Supervision for midwives. This information sheet will tell you what is involved in the study and help you to decide whether you wish to take part. Please read this information carefully. If you have any questions, please ask.

What is this research?

Clinical Supervision sessions are a facilitated, structured, deeply reflective process that enables participants to further develop their professional practice. Usually, the sessions are held in-person. To date, there is no evidence on the acceptability from midwives attending Clinical Supervision online.

The aim of this study is to see how midwives feel about online Clinical Supervision.

What does this research involve?

You are invited to attend online group Clinical Supervision sessions which will be provided monthly via PEXIP for six months. The sessions will each run for one hour. You will then be asked to complete a short, anonymous online survey that should take you about 10 minutes to complete. You will also be asked if you would like to be interviewed about your experience of attending the online Clinical Supervision sessions.

If you agree to be interviewed, the interview will be online and audio-recorded to enable the researcher to analyse your responses. You will not be identified in any

written reports. All your responses will be treated as confidential. The interview will be scheduled to take place within one month of the conclusion of the Clinical Supervision sessions and will take approximately 30 minutes. During the interview you will be asked for more information about your experience of attending online Clinical Supervision sessions.

This study is being conducted as part of a University of Technology Sydney (UTS) Masters of Midwifery study, and the Clinical Supervision sessions will be provided by Ms. Helen Donovan, who is a Registered Midwife, and has been trained in the facilitation of Clinical Supervision.

The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in any such presentation or publication.

What are the risks associated with this research?

It is not anticipated that you will be exposed to any harm if you choose to take part in this research. It is possible that recounting stressful workplace incidents may cause some distress, either during the Clinical Supervision sessions or when completing the survey. If you do experience any distress, the supervision session will be stopped, and you can seek support from your local EAP (Employee Assistance Program). You will be provided with details of how to contact your EAP during sessions, and when completing the survey.
Taking part in this research will not cost you anything, nor will you be paid by the researcher for your time. Participation is entirely voluntary, and you can withdraw at any time without needing to give a reason. You can withdraw by contacting Christine Catling at christine.catling@uts.edu.au or Helen Donovan at helen.donovan@uts.edu.au

Participating in this research will not affect your employment as a midwife in any way. Please note that the questionnaire is anonymous.

If you wish to withdraw from the study, you can simply cease attending the sessions or not complete the survey or attend an interview. Note that once the survey is completed the information submitted will be kept in a pool of anonymous data and it will not be possible to remove the information.

What will happen to information about me?

All the information from the study will be treated confidentially. Only the researchers named above will have access to it. The data will be analysed by the researchers at UTS. All data used for journal articles and presentations will be de-identified (none of your information will be identifiable). The files will be retained for 5 years after the completion of the study.

De-identified data will be stored online in a password protected secure research database, REDCap (Research Electronic Data capture) accessed by Christine Catling and Helen Donovan at UTS. Similarly, the platform will be used to manage the collection and storage of survey data. If you would like a copy of the final report, you can nominate that on the consent form.

What if I would like further information about the study?

If you would like to know more about the study, and your potential involvement, please contact Christine Catling (Christine.catling@uts.edu.au) or Helen Donovan (helen.donovan@uts.edu.au) who will be able to answer any questions you may have.

Ethics approval

This research has been reviewed and approved by the UTS Ethics Committee. The approval number is *ETH22-7201*.

Complaints or concerns about the study

This study has been approved in line with the University of Technology Sydney Human Research Ethics Committee guidelines. If you have any concerns or complaints about any aspect of the conduct of this research that you wish to raise independently of the research team, please contact the Ethics Secretariat on ph.: +61 2 9514 2478 or email: Research.Ethics@uts.edu.au] and quote the UTS HREC reference number ETH22-7201. Any matter raised will be treated confidentially, investigated and you will be informed of the outcome.

The conduct of this study at Wollongong and Shoalhaven District Memorial Hospitals has been authorised by the Illawarra and Shoalhaven Local Health District. Any person with concerns or complaints about the conduct of this study may also contact the Research Governance Officer on Phone: 02 4253 4819, or via email at ISLHD-ResearchGovernance@health.nsw.gov.au and quote project number "AR22/004".

All information is confidential and will be handled as soon as possible.

Thank you for taking the time to consider this study.

This information sheet is for you to keep

Appendix 1b: Recruitment flyer

Appendix 1c: Distress Protocol

The following protocols will be put in place should a participant become distressed during the Group Clinical Supervision (GCS) sessions, and if the GCS Facilitator experiences distress. The Facilitator will ensure these strategies are familiar to them prior to commencing the GCS sessions.

Below is the step-by-step guided protocol adapted from Draucker, Martsolf & Poole (2009) Developing Distress Protocols for research on Sensitive Topics. *Archives of Psychiatric Nursing* 23 (5). pp 343-350).

Participants' Safety and Distress Protocol

Distress
- A participant indicates mild or moderate emotional distress OR
- Exhibits behaviours suggestive that the GCS session is too stressful such as crying, shaking etc

Strategy1
- Pause the session
- The researcher (who is a health professional) will offer immediate support
- Assess mental status: Tell me what thoughts you are having? Tell me what you are feeling right now? Do you feel you are able to go on about your day? Do you feel safe?

Evaluate
- If participant feels able to carry on, resume session
- If participant is unable to carry on, go to strategy 2

Strategy2
- Discontinue the session
- Encourage the participant to receive immediate support via telephone. These are EAP or the Mental Health Line (1800 011 511) or PANDA National Helpline (1300 726 306).
- Offer to help the participant with contacting these support services, if necessary.

Follow up
- Follow participant up with courtesy call or email (if participant consents).
- In the case of a phone call, the Facilitator will ask for the participant's phone number, store it in a secure place and destroy it immediately after the phone call, if the participant is feeling well and safe.

Facilitator's Safety and Distress Protocol:

Safety & Distress

- The Facilitator organises monthly debriefing by an exprerienced GCS Facilitator external to the project.

Strategy

- If there are any signs of distress, the Facilitator will seek support of the CI, as well as having monthly debriefing with an experienced GCS Facilitator.

Evaluate

- Are there alerted emotional states prior, during or after the sessions?
- Are there any feelings of potentially "challenging" or "difficult" sessions?
- Has the Facilitator been attending regular scheduled debriefing sessions?

Follow up

- The facilitator will access their CI, and/or a GP/counselling service (EAP) if needed.

Appendix 2: Contents of survey

Demographics

 Please complete the survey below. Thank you!

Participant Information Sheet - please read and consent below [Attachment: "Updated PIS and consent ISLHD v 1.2 Sept 22 FInal_.docx"]
I have been given the opportunity to read the I consent Participant Information Sheet and I consent to taking part in the study
Thank you for clicking on the link to complete this survey. This survey should take about 10 minutes to complete.

1. Where did you study for your Midwifery Qualification?

- Hospital based training
- University Graduate diploma University Undergraduate
- BMid
- Other If other, please give details of education

  _____

2. How old are you?
- Under 30
- 31-40
- 41-50
- Over 50

3. How long have you been a Midwife?

- Less than 5 years
- 6-10 years
- 11-15 years
- More than 15 years

4. Do you work full-time? Yes/No - If no, how many hours per week do you work?

Please click on the SUBMIT button to progress to the next section

Appendix 3: Clinical Supervision Evaluation Questionnaire

We would like to hear your thoughts regarding Clinical Supervision and your experiences in this section.

1) I believe that any confidences I share are respected
Strongly agree   Agree   Disagree   Strongly disagree   No opinion

2) Clinical Supervision has helped me feel more confident about dealing with my job

Strongly agree   Agree   Disagree   Strongly disagree   No opinion
3) I have gained new clinical insights through supervision

 Strongly agree   Agree   Disagree   Strongly disagree   No opinion

4) There is mutual trust between the members in my group

Strongly agree   Agree   Disagree   Strongly disagree   No opinion
5) Being part of a Clinical Supervision group is helping to develop my self-awareness

Strongly agree   Agree   Disagree   Strongly disagree   No opinion
6) I feel safe sharing clinical issues in supervision sessions

Strongly agree   Agree   Disagree   Strongly disagree   No opinion
7) The purpose of Clinical Supervision is to enable clinicians to feel confident in their own practice

 Strongly agree   Agree   Disagree   Strongly disagree   No opinion

8) I feel confident about bringing issues to Clinical Supervision
Strongly agree   Agree   Disagree   Strongly disagree   No opinion

9) Clinical Supervision has helped me cope with any stresses at work I may have
Strongly agree   Agree   Disagree   Strongly disagree   No opinion

10) Clinical Supervision has made me more aware of areas of skill I need to improve

Strongly agree   Agree   Disagree   Strongly disagree   No opinion
11) Clinical Supervision has definitely had a positive impact on the quality of care I provide

Strongly agree   Agree   Disagree   Strongly disagree   No opinion

12) There are well established ground rules in my group
Strongly agree   Agree   Disagree   Strongly disagree   No opinion

13) The purpose of Clinical Supervision is to improve care for women and babies

Strongly agree   Agree   Disagree   Strongly disagree   No opinion

14) I am clear about what I want to get out of Clinical Supervision

Strongly agree   Agree   Disagree   Strongly disagree   No opinion

Please click on the SUBMIT button to progress to the next section

Appendix 3 (b): CSEQ Scoring:
The Clinical Supervision Evaluation Questionnaire

Scoring and interpretation

The CSEQ has fourteen items made up of three subscales:

Purpose: three statements (1, 9, 14)

Process: five statements (2, 3, 5, 10, 13)

Impact: six statements (4, 6, 7, 8, 11, 12)

Each statement is rated on a Likert-type scale, with scores assigned as follows:

Strongly agree	Agree	No Opinion	Disagree	Strongly disagree
5	4	3	2	1

Lowest total score is therefore 14; highest is 70. A score of over 56 represents a positive response to Clinical Supervision; a score of 42 or less represents a negative view, and between 42 – 56 is seen as neutral.

Appendix 4: Theoretical Framework of Acceptability

1) How do you feel about attending the Clinical Supervision sessions using videoconferencing? _____

2) How much effort does it take to attend the Clinical Supervision sessions online?

3) How does the online Clinical Supervision align with your professional values?

For example, engaging in reflective practice, or continuing professional development.

_____

4) How confident do you feel using the technology required to join the online Clinical Supervision sessions? _____

5) Did Clinical Supervision interfere with your work or personal activities? e.g. Did it require you to come to work early or leave late? ~Did you have to miss a work/personal activity or break?

_____

6) Do you think that attending the online Clinical Supervision sessions has helped you professionally? e.g. Has it changed how you approach your work? Have you become more reflective Do you feel more supported/less stressed?

_____

7) Does online Clinical Supervision encourage active participation? Do you think the online platform inhibits contribution? How easy did you find it to speak up during the sessions?

_____

Appendix 5 Interview Questions:

Questions for the one-to-one interviews included but not limited to:

1. Tell me about your experience of attending Clinical Supervision online.

2. Could you tell me about things that made attending the online supervision difficult?

3. Could you describe what worked well for you and why?

4. Would you recommend attending Clinical Supervision online, and why?

5. Tell me about how you think attending the sessions has changed your practice?

Appendix 6: Ethical approvals

2.1 UTS HREC Approval letter

Dear Applicant,

Re: ETH22-7201 - "Midwives' perceptions of online Clinical Supervision"

Your local research office has reviewed your application and agreed that it now meets the requirements of the National Statement on Ethical Conduct in Human Research (2007) and has been approved on that basis. You are therefore authorised to commence activities as outlined in your application, subject to any conditions detailed in this document.
You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.

Your approval number is UTS HREC REF NO. ETH22-7201

Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.

The following standard conditions apply to your approval:

- Your approval number must be included in all participant material and advertisements. Any advertisements on Staff Connect without an approval number will be removed.
- The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat.

- The Principal Investigator will notify the Committee of any event that requires a modification to the protocol or other project documents and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.
- The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property.
- The Principal Investigator will report to the UTS HREC or UTS MREC annually and notify the Committee when the project is completed at all sites. The Principal Investigator will notify the Committee of any plan to extend the duration of the project past the approval period listed above.
- The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations).

- The Principal Investigator will notify the Committee of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval.

If you have any queries about this approval, or require any amendments to your approval in future, please do not hesitate to contact your local research office or the Ethics Secretariat.

MNCLHD Access approval

Health
Mid North Coast
Local Health District

Our Ref: MNC AR-2022/13

9 August 2022 (re-issued 10th August 2022)

Helen Donovan

School of Nursing and Midwifery

Building 11, University of Technology

15 Broadway, Ultimo
Sydney NSW 2007

Email: Helen.Donovan@uts.edu.au

Dear Helen

Re: Access Request: Midwives' Perceptions of Online Clinical Supervision
(HREC Approval Ref: ETH22-7201)

Thank you for submitting an access request for the above referenced project for
***Maternity Units at Port Macquarie Base Hospital, Coffs Harbour Health
Campus, Macksville District Hospital and Kempsey District Hospital***
located within the Mid North Coast Local Health District.

This application has been **<u>authorised</u>** as set out in HREC approved documents.
This approval allows for ***distribution of poster*** via email to potential participants
(staff working within the above-mentioned Maternity Units).

As this has been approved under the access request review pathway, MNCLHD staff should not be involved in collating data, recruiting or enrolling participants, study design and/or data analysis for this project.

The following documents are noted as part of this approval:

- HREC approval correspondence dated 12th July 2022

- Ethics Application dated 12th July 2022

- Protocol, Version 1.2, dated 5th June 2022

- Distress Protocol, Version 1.2, dated June 2022

- Poster, Version 2.1, dated July 2022

- Clinical Supervision Evaluation Questionnaire (CSEQ), Version 1, dated 2nd June 2022
- Online PIS, Version 1, dated 2nd June 2022

- Interview PIS and Consent, Version 1.2, dated 5th June 2022

Please liaise with Katrina McLeod, A/District Midwife Manager with regards to the distribution of poster to potential participants as approved above. Katrina can be contacted via telephone ⬚⬚⬚⬚⬚⬚⬚⬚ or email at katrina.mcleod@health.nsw.gov.au.

For any future correspondence to this office in relation to this project, please use the MNCLHD Reference: ***MNC AR-2022/13.***

I wish you well with the project. Please don't hesitate to contact me via email at MNCLHDRGO@health.nsw.gov.au or telephone ⬚⬚⬚⬚⬚⬚⬚⬚ for any further assistance.

Yours sincerely,

Production Note:
Signature removed prior to publication.

Colleen Nosworthy

Research Governance Officer

Cc: Katrina McLeod, A/District Midwife Manager – MNCLHD

Conditions of approval:

HREC Amendments and Progress Reports: The RGO does not require updates on any HREC approved amendments and/or annual/final reports going forward following this authorisation.

However, you will need to seek ***additional approval*** if the level or type of assistance requested from the LHD changes from original request.

ISLHD Access Approval

ISLHD-ResearchGovernance <ISLHD-ResearchGovernance@health.nsw.gov.au>
To: Helen Donovan

Thu 03/11/2022 10:06

Updated PIS and consent ISLHD v 1.2 Sept 22 FInal_.docx

Date of Decision Notification: **02/11/2022**

Dear Helen Donovan,

Thank you for submitting the following access request application to the ISLHD
Research Governance Office.

We are pleased to advise that this access request has been **authorised**.

PROJECT DETAILS:
HREC reference number: ETH22-7201
HREC Approval date: 12/07/2022
HREC Expiry date: 12/07/2022
Project title: Midwives' perceptions of online Clinical Supervision
Coordinating Principal Investigator: A/Prof Christine Catling
Documents:

- Ethics Committee approval_12July2022 (for period of 5 years)
- Ethics Committee Amendment approval_ 07Oct2022
- Protocol V1.2_30June2022
- PIS and consent ISLHD_V1.2_12Sept022_Final.
  Please note this document has been updated to include the
  following information in the Complains section ""The conduct of this
  study at Wollongong and Shoalhaven District Memorial Hospitals
  has been authorised by the Illawarra and Shoalhaven Local Health
  District, any person with concerns or complaints about the conduct
  of this study may also contact the Research Governance Officer on
  Phone: 02 4253 4819, or via email at ISLHD-
  ResearchGovernance@health.nsw.gov.au and quote project number
  "AR22/004". **This updated version is attached, and is the only
  version to be used within ISLHD**

- Study questionnaire_V1.2_June2022
- Distribution email ISLHD

Site authorisation will cease on the date of HREC expiry **(12/07/2027)**.

At this time, we also remind you that, in order to comply with the Guidelines for Good Clinical Research Practice (GCRP) in Australia, and in line with additional requirement of NSLHD, the Chief Investigator is responsible to ensure that:

1. The HREC is notified of anything that might warrant review of the ethical approval of the project, including unforeseen events that might affect the ethical acceptability of the project.

2. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and are submitted to the HREC for review, are copied to the ISLHD Research Governance Office.

3. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project are to be submitted to the ISLHD Research Governance Office.

4. The annual report acknowledgment from the Lead HREC should be submitted to the ISLHD Research Governance Office.

Kind Regards,

ISLHD Research Governance Office
Wollongong Hospital, Block C, Level 8
ISLHD-ResearchGovernance@health.nsw.gov.au

Appendix 7: Role Development Supervisor Reflection Guide

Supervisor Reflection Guide

The reflection prompts can be used following a standard clinical supervision session format, or a guided session (Exploring Your Work Environment or This Year/Next Year)

- Preparation of physical space & 'equipment' needed for the session

- 'Warm-up' to the session & awareness of the supervisor role; reduction of interruptions (eg. phones); first sentences including confidentiality

- Awareness of session structure and timing to allow adequate opportunity to explore the developed/progressive role and actions/steps (standard session format) **or** use the prompts (guided session)

- What techniques did you use in the session? How appropriate and useful were the techniques to the outcome of the session?

- What challenges did you face when providing the session, and how did you overcome them/adapt the session?

- What went well?

- How did the supervisee respond to the session (from your observation & awareness)?

- Feedback from supervisee (following completion of the session)

- What did you learn from this session in relation to being a supervisor, and how will you incorporate your learning into practice?

- Other reflections/learning?

Clinical Supervision

Ways of Working

- **Confidentiality***

- **Respect – for each other, for the process of Clinical Supervision and for the facilitator**

- **Commitment**

- **Non-judgmental**

- **Phones on silent (or diverted)**

- **Active listening**

- **Kindness**

- **Be punctual – or let us know if you can't attend**

- **Active participation**

***Confidentiality is non-negotiable and essential for psychological safety within the group**

UTS Stash   ⊙

Appendix 8: Research Data Management Plan (RDMP)

The acceptability and efficacy of online Clinical Supervision for Midwives

Description

A Masters of Midwifery (Research) project examining the acceptability and
efficacy of Clinical Supervision provided via online platform (MS Teams) to 3
groups of midwives from regional NSW. Data is being collected via online survey
and one-to-one interviews. This is a mixed methods study.

Expand/Collapse all

- Project

Project overview

Project name
The acceptability and efficacy of online Clinical Supervision for Midwives

Research Master Project Code / Student ID

☑ HDR student project

Project description
A Masters of Midwifery (Research) project examining the acceptability and efficacy of Clinical Supervision provided via online platform (MS Teams) to 3 groups of midwives from regional NSW. Data is being collected via online survey and one-to-one interviews. This is a mixed methods study.

Keywords
Clinical Supervision, Midwives

Start date
08/02/2021

End date
27/03/2025

Funders
University of Technology Sydney

Grant ID

People

First-named chief investigator / UTS supervisor

Name	Email	ORCID
Christine Catl	Christine.Catling@uts.edu.au ing	

Data manager

Name	Email	ORCID
Helen Donov	helen.j.donovan@student.uts.edu.au an	

Contributors

Name	Email	ORCID
Allison Cumm ins	Allison.Cummins@uts.edu.au	

Additional supervisors

Name	Email	ORCID

Ethics and Security

Initially your research data is classified as UTS Internal. To improve the accuracy of this classification, please answer the following

Information Security Classification UTS:
Confidential

Does the research involve: Human
participant data

Will the data you collect from individuals include personal
information? No

Will the data you collect from individuals include sensitive personal
information other than health information? No

Will the data you collect from individuals include health
information? No

Will any data or information be individually identifiable or potentially
re-identifiable (i.e. include codes) at any stage of the research? No
Is Ethics approval required for your project?
Yes

- Data collection and storage

Data retention and disposal

Minimum retention period
5 years (general research)

The data steward is: Christine
Catling

Have you made commitments to destroy part of the data prior to
end of retention period (e.g. original recordings, linking/code
files)? Yes
If participant data will be retained for secondary use by yourself or
shared with other researchers, will you obtain:

Data collection and storage

Please provide a brief description of your data collection methodology
Mixed methods comprising online survey with quantitative and qualitative
elements. Also, an online one-to-one interview

Predominant file type(s), e.g. textual, tabular, image or
recording. Give file format if known textual

Data storage location
UTS provided survey platform (e.g. Qualtrics, REDCap, etc)

If other, provide further details: (Including access arrangements for the
minimum retention period)

- Access and rights

Access and rights

Copyright and intellectual property owners of data created in project
Higher Degree Research Student

Please list any other owners:

Access after the project will be
Mediated, by permission from the data manager

Are you using any secondary or third-party data?
No
Licences or Agreements:

- Research Workspace

Research Workspace
Associated workspaces

Name	Description	Location	Type

Appendix 9: Confirmation of completion of Stage 1 assessment letter

⚛ UTS

STAGE 1 CONFIRMATION OF CANDIDATURE ASSESSMENT OUTCOME LETTER

UTS: HEALTH

Date 25th January 2022

Dear Helen

Thank you for presenting to your Stage 1 assessment panel on 25 January 2022.

Following review of the written submission, presentation and the interview, the panel was of the unanimous view that the Stage 1 assessment is **satisfactory** and the candidature be **confirmed**. On behalf of the panel and the Faculty, congratulations!

You met with the panel after the review, and we informally conveyed our decision to you. Kindly discuss the assessment feedback with your supervisors who may also raise additional aspects for consideration.

On behalf of the panel and the Faculty, my best wishes for your continued progress in this candidature.

Signed by the Panel Chair:	Production Note: Signature removed prior to publication.		25/01/2022
Endorsed by Faculty RAO	Rob Duffield	Production Note: Signature removed prior to publication.	27/01/2022

cc: Supervisor/s, GRS & Student File

Appendix 10: Examples of Role Development techniques

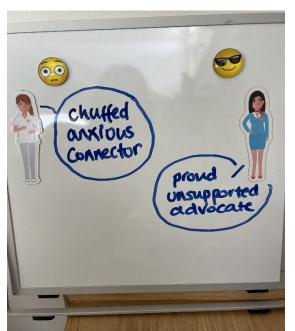Image 1 & 2: Use of whiteboard in online sessions

Image 3 & 4: Use of 3-D figures in in-person sessions

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