

Clinical Supervision

Study Guide 2

40358B

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He has been an external examiner for undergraduate clinical supervision programmes at the University of Wales, Swansea and a member of a Working Party on the development of clinical supervision standards across Wales. Now working as a freelance continuing professional development consultant and coach he retains an academic portfolio, having been a visiting lecturer at the University of Westminster and currently a part time lecturer at City College Norwich (an Associate College of the University of East Anglia). He has recently published an edited multi-professional second edition (2007) of *Practising Clinical Supervision: A Reflective Approach for Health Professionals* and developed an accompanying resource website www.supervisionandcoaching.com. His research interests include developing appreciative and strengths-based approaches to support the organisational implementation of clinical supervision, as well as exploring alternatives to more traditional face to face encounters. He is a practising supervisee and experienced clinical supervisor within the NHS and independent sectors.

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Learning Outcomes

On completion of this study unit you will be able to:

- Explore the political, professional and economic context of clinical supervision
- Using the literature, develop a definition of clinical supervision relevant to your practice area
- Critically evaluate the range of models available for clinical supervision
- Choose, stating the rationale, an appropriate model for your clinical area
- Demonstrate deep understanding of the process of supervision.

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1 Introduction

How to Use This Study Guide

This is the second of two study guides on clinical supervision. Together they form a complete module as a component part of a BSc in Nursing, therefore all of the examples and referenced materials are nursing focused. Whilst many of the underlying principles of clinical supervision will also be relevant to other health professionals, this should be with reference to any specific advice and guidance offered by their own regulatory bodies.

This second study guide builds on your supervisee experience of clinical supervision in Study Guide 1. It considers the requirement as a new supervisor (whilst still continuing to be a supervisee) to gain a broader understanding of some of the common models and approaches in clinical supervision. It will equip you to be able to make some informed and active choices about your current skills, as well as those that could be developed further when practising clinical supervision. The emphasis in this study guide is on the role of the supervisor.

It continues to be an essential requirement of the module as a whole that you carry on accessing clinical supervision yourself. This might be with the same clinical supervisor that you used throughout Study Guide 1 or, you might see the undertaking of Study Guide 2 as an opportunity to change your supervisor.

The focus for what you will now take to clinical supervision as a supervisee in this study guide will alter from being a clinical practice issue, to topics that specifically relate to being a new clinical supervisor in practice to a peer colleague. Continuing to be a supervisee yourself in clinical supervision, whilst acting as a clinical supervisor to a peer colleague and maintaining your reflective notes or supervision documentation, will ensure you are able to demonstrate evidence to complete the activities in Study Guide 2, as well as the Formative and Summative Assessments to complete the module.

Before commencing Study Guide 2 it is essential that you ensure you have met all the requirements in Study Guide 1 BEFORE then acting as a clinical supervisor to a peer colleague in practice. The requirements to begin Study Guide 2 are to have completed all the activities in, and obtained feedback from the module tutor on, the TWO Formative Assessments in Study Guide 1. During Study Guide 2 you will need to complete all the Activities and ONE Formative and ONE Summative Assessment. Additionally, to complete Study Guide 2, you must be able to demonstrate evidence of having personally accessed a *minimum of 4-6 clinical supervision meetings* with an experienced clinical supervisor of your choice (and take issues as a continuing supervisee that relate to your giving supervision to a peer colleague as a new supervisor) AND have *offered a minimum of 4-6 clinical supervision meetings to a PEER COLLEAGUE who has agreed beforehand that you may act as their clinical supervisor on a one-to-one basis.*

It is an essential requirement that you both obtain permission from your respective line managers BEFORE beginning clinical supervision in practice for the duration of Study Guide 2. Not unlike Study Guide 1, it is important at an early stage of working through Study Guide 2 that you contact the module tutor if you are unable or unlikely to meet any or all of these requirements, as alternative arrangements might then need to be made.

You will be invited throughout Study Guide 2 to reflect on each of the sections using your reflective notes or supervision documentation that you commenced in Study Guide 1 to help you form a working template to monitor the effectiveness of your clinical supervision to a peer colleague.

The core textbook for the clinical supervision module is:

Driscoll, J. (ed.)(2007) *Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals* (2nd edn) Bailliere Tindall, Elsevier, Edinburgh, UK

In addition to the core textbook, at the beginning of each of the numbered sections in each study guide there is also a Guided Reading list. This contains suggestions for further books and articles to examine during your studies in addition to the sources that have been referenced throughout the study guide. In some instances in the study guides, you will note that you an activity may be directly linked and guide your reading as it has a specific focus on a particular learning outcome(s) of the module. Of course you have the option of using the Guided Reading suggested or, alternatively, choose a source of your own which you feel to be more relevant or accessible.

Sections are set out as in Study Guide 1, with the learning objectives clearly outlined. In each section you will also be directed to specific referenced sources related to the content of the study guide, such as journal articles, textbooks and chapters, as well as key policy documents from your own practice There is also an accompanying introductory CD-ROM on clinical supervision produced by Gwent Healthcare NHS Trust used with their permission, as well as a resource website set up by the author of these study guides **www.supervisionandcoaching.com** This website gives you information that will enable you to develop your skills throughout both study guides.

Each section will also include learning activities. These activities will not need to be submitted but are designed to enable you to link the theory of clinical supervision to your individual practice and provide evidence (perhaps as attached appendices) for your written formative and summative assessments.

At the end of each section, key learning points have been outlined and some progress checks are included throughout to help you identify your development throughout the study guide.

It is acknowledged that some students undertaking the module may already be familiar with the term clinical supervision in nursing practice or have had some direct experience already, as in most cases you will already be qualified practitioners. Generally speaking, these study guides assume little if no experience of clinical supervision in practice but are flexible enough to help build on your existing expertise and knowledge of clinical supervision.

Reflective practice is a recurring theme that runs through both study guides. Actively 'noticing' and capturing your reflections in clinical supervision practice through journal work as a supervisee (in Study Guide 1) and supervisor (in Study Guide 2) is an important aspect of the clinical supervision module. Written reflections can be used as supporting evidence in activities and written assignments, as is the possibility, if you are able, of audio recording or videoing (with permission) clinical supervision meetings. You would be required to discuss the latter with your module tutor before you begin.

Based on the author's background in teaching and education and supervisory experience, both study guides use reflective practice as the basis for clinical supervision, whether to facilitate as a supervisor, or to reflect on practice as a supervisee. However, the ever increasing literature on clinical supervision in nursing also looks to other disciplines such as counselling, psychotherapy and social work for guidance in developing different approaches within the process of clinical supervision. Therefore, an eclectic stance is taken in both study guides, acknowledging the specialist nature of more therapy-orientated supervision, along with more general principles that might suit nursing practice.

It is important that you keep up to date with developments in clinical supervision reported in nursing journals, books and websites. Although you will be directed to specific reading in this study guide, you are also expected to carry out your own literature reviews around the topics to increase your knowledge and understanding of the content being studied. By expanding your literature searching, or reading widely, you will be able to become more practice specific and informed about key areas for your own practice arena. Perhaps you might also add to the clinical supervision knowledge base through your own written assignments as well as opening up conversations through sharing your thoughts and learning with peer colleagues.

Finally, bear in mind that the learning for clinical supervision practice just like any other nursing practice is lifelong, provided you remain open to learning. In this respect, completion of the clinical supervision module represents a starting point on that road to clinical supervision discovery and is not in itself a destination.

Assessment

This study guide contains a formative and a summative assessment. A formative assessment is designed to support specific aspects of your learning and is an opportunity for feedback by the module tutor as you progress through each of the study guide(s). The learning activities and further reading in each section will prepare you for both the formative and summative assessment.

In Study Guide 2 you will need to have completed all of the activities and ONE formative assessment. In order to complete the Clinical Supervision module as a whole, you will ALSO need to complete the summative assessment.

2 Getting Started in Becoming a Clinical Supervisor in Practice

The main aims of this section are to:

- analyse personal and professional expectations for clinical supervision as a new supervisor
- reflect on the experience of being a supervisee in Study Guide 1 as guiding the role of a new clinical supervisor
- review the role and functions of clinical supervision from the perspective of a clinical supervisor
- examine ways in which the clinical supervisor can create a suitable environment for clinical supervision meetings.



Guided Reading

- Avidsson, B. Fridlund, B. (2005) *'Factors influencing nurse supervisor competence: a critical incident analysis study'* Journal of Nursing Management (13): 231-237.

Consider the personal and professional factors a supervisor needs to take into account to carry out effective clinical supervision in practice (Learning Outcomes 1, 3 & 5)

- Brown, A. Bourne, I. (1996) *The Social Work Supervisor Open University*, Buckingham, UK, (Chapter 3 Supervision and power: an anti-oppressive perspective pages 32-49.

Reflect on whether it is possible to empower supervisees as a supervisor in what might be considered an unequal relationship (Learning Outcomes 1 & 5)

- Driscoll, J. (2000) *Practising Clinical Supervision: A Reflective Approach Bailliere Tindall* (in association with the Royal College of Nursing), Elsevier, Edinburgh, UK, (Chapter 7 Essential skills for clinical supervisors pages 101-122.

Examine some key skills to develop as a new supervisor beyond the first contractual meeting (Learning Outcomes 3, 4 & 5)

Continued

- Jones, A. (2006) '*Clinical supervision: what do we know and what do we need to know? A review and commentary*' *Journal of Nursing Management* (14): 577-585.

Reflect on what elements of the clinical supervisory relationship need to be further developed to support the complexities of professional practice (All Learning Outcomes)

Personal and Professional Expectations for Clinical Supervision as a Supervisor

One of the distinct advantages of having had a working experience of being a supervisee in Study Guide 1 prior to becoming a practising clinical supervisor, is that you will also have developed a working knowledge of what it is like to be at the receiving end of clinical supervision yourself. It might be argued that the slow uptake in the development of clinical supervision in nursing has been partly due to developing enough clinical supervisors to go around, possibly at the expense of supervisee development. A not unusual starting point for training a clinical supervisor was to present a list of characteristics and roles which, aside from being confusing and idealistic, may not have matched supervisee (or supervisor) expectations in practice.

Not surprisingly perhaps, the knowledge of such characteristics to aspire to as clinical supervisors in nursing, was often 'borrowed' from disciplines with an established culture of (often mandatory) supervision, such as counselling, psychology, psychotherapy and social work (Sloan 2006 page30), which differed from ideas about clinical supervision in nursing. What perhaps seems self evident now with the development of clinical supervisors in the 21st Century, is that to be really helpful to supervisees it is essential that new supervisors have engaged in the process themselves (as supervisees) as part of the knowledge and learning for clinical supervision. Interestingly, this form of experiential learning process now being used in clinical supervisor development is useful knowledge 'borrowed' from those disciplines cited previously and is being developed as part of clinical supervisor training in nursing.

It is likely that 'good' clinical supervision or having benefited from a 'good' clinical supervisor (whatever that may mean to you) has begun to shape your ideas and skills in reflection, helped you become more self aware of how you carry out practice and, in doing so, has supported as well as challenged you as a practitioner. So, rather than look at lists of ideal supervisory characteristics and compare these to your role as a clinical supervisor, it might be useful to once again return to your own supervision 'history' alluded to in Study Guide 1 as the basis for examining your own personal and professional expectations as a clinical supervisor.



Activity 1

1 hour

Using worked examples taken from your reflective notes or supervision documentation as a supervisee in Study Guide 1, write short notes illustrating how in your opinion your clinical supervisor role modelled (or not) what you expect your own role to be as a new clinical supervisor to a peer colleague in practice.

Feedback for this activity is given at the end of the study guide

Whether as a supervisee or clinical supervisor, reflecting on our own supervision histories and selected experiences can be a rich source of inspiration, filling us with anticipation and excitement, as well as sometimes disappointment. However, such experiences can also provide options and ways to improve, provided we are open to them. With the latter, it can be tempting to keep such uncomfortable reflections to ourselves, keeping them as jottings in notes or reflective diaries, which is not as useful as then sharing those findings with others. Being reflective on practice, as in clinical supervision, provides a learning opportunity and a powerful way of influencing change in future practice including supervision practice. For instance, Launer (2003 p93) describes clinical supervision as:

"...an opportunity for a professional to change a story about a working encounter by holding a conversation with another professional..."

A key element of supporting change through clinical supervision is to be able to obtain some open and honest feedback through such reflective conversations. As a clinical supervisee in Study Guide 1 it is very likely that you received feedback on aspects of your practice. As part of your emerging role as a clinical supervisor in Study Guide 2, the ability to give feedback will also become an additional responsibility. In what is often set out as an equal partnership (Nicholls 2007 p81) or supervisory alliance (Bond & Holland 1998 p77) distinguishing clinical supervision from other forms of supervision in nursing, it is not difficult to see how power inequalities (Browne & Bourne 1996 p33) can occur if feedback is given in only one direction, e.g. from the supervisor to the supervisee. A committed clinical supervisor will be open to feedback by the supervisee on their supervisory performance, just as the clinical supervisee is expected to be open to receiving feedback on their performance to the clinical supervisor as a practitioner, and this will serve to strengthen the effectiveness of the supervisory relationship. For more detailed ideas about ways of giving and receiving feedback in clinical supervision, read Hawkins & Shohet (2000 p113), Driscoll (2000 page115) or a resource of your own choice.



Activity 2

2 hours

- a** Building on Activity 1, consider what elements of clinical supervision you would like to offer feedback on to the clinical supervisor you used in Study Guide 1.

- b** Arrange a meeting with that clinical supervisor to give and receive some feedback on your clinical supervision experience as a supervisee with the intention of gaining more insight into managing the expectations of being a clinical supervisor in practice.

- c** (Optionally), you might wish to make inquires at this meeting as to whether your clinical supervisor is prepared to continue offering you clinical supervision whilst you act as a new clinical supervisor to a peer colleague as a requirement for Study Guide 2, or whether you need to approach another experienced clinical supervisor from practice.

Feedback for this activity is given at the end of the study guide

Whatever the personal reasons or practicalities for continuing with your clinical supervisor or not, it is important that all parties have had the opportunity to both give and receive feedback on the experience of clinical supervision. Your meeting in Activity 2 might have meant a formal closure to your clinical supervision activities together in Study Guide 1. Alternatively, it might have become a new beginning, opening up further possibilities as you take on a dual role as an ongoing supervisee AND as preparing to take on the role of supervising a peer colleague during Study Guide 2.

In addition to personal reasons for wishing to become a clinical supervisor, there will also be organisational as well as professional expectations of you in your new role as a clinical supervisor in practice. You will need to refer to your organisational policy or guidelines on clinical supervision, in which the responsibilities of the clinical supervisor will be outlined in detail. If your organisation does not yet have a policy on clinical supervision, read the chapter by Power (2007) in the core textbook or Driscoll (2007a) online in the reference list.

The regulating body for nursing and midwifery, the Nursing and Midwifery Council, in their advice on clinical supervision (NMC 2006), supports the establishment of clinical supervision as an important part of clinical

governance (DOH 1999) and the use of reflection as a vehicle in the interests of maintaining and improving standards of patient/client care. The NMC (2006) define the clinical supervision relationship as:

“..... a practice-focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor.....”

In relation to being a clinical supervisor, there would seem to be some emerging professional expectations and associated responsibilities when working with a supervisee that focus on:

- increasing the supervisee’s awareness and understanding of professional issues relating to practice generally
- increasing the supervisee’s awareness and understanding of the way they personally practice
- guiding and supporting the development of knowledge and skills in the supervisee’s practice
- encouraging the supervisee to reflect on ways that the standards of patient/client care are being maintained (or not) within their own sphere of practice.

At this stage of Study Guide 2, as you examine your personal, as well as professional expectations for becoming a working clinical supervisor, it may be becoming apparent that this will not just require your commitment, but also some support to be able to function effectively. It is very likely that at this stage you might be experiencing quite natural feelings of anxiety, or uncertainty, that you can fulfil the role of being a clinical supervisor to a peer colleague for a minimum of 4-6 meetings, as well as meet the demands of your clinical practice. An additional expectation (and perhaps burden) of completing Study Guide 2 is that you also continue to access ‘supervision on your giving of supervision’ and remain a supervisee.

Part of any successful organisational implementation of clinical supervision is the managerial responsibility to ensure that clinical supervisors not only have training, but access to support networks in carrying out their supervisory role.



This is why, although perhaps seen as an additional burden, an essential requirement of Study Guide 2 is to continue as a supervisee in clinical supervision. The purpose of this is to ensure that you are able to discuss and get support for some of the challenges you will face in your new role by those who have experience as clinical supervisors. You might also need to seek further support from your line manager in practice, e.g. managing your workload to supervise effectively in practice. If you do not feel you are able to meet this requirement of giving as well as receiving clinical supervision for yourself, you must speak to the module tutor before continuing Study Guide 2.

Finally, being a clinical supervisor is also a rewarding experience, despite the challenges. You may wish to write down in your reflective notes some of your motives or reasons for wanting to become a clinical supervisor in practice before you begin supervising. It can be helpful after taking time out to 'actively notice' and record your motives to revisit these from time to time to see whether these have changed. This can be particularly revitalising when, as will happen, challenges surface about your role as a clinical supervisor in practice.

The Role and Functions of the Clinical Supervisor

In getting prepared to understand what is required of a clinical supervisor in practice, there are a number of places from which you can obtain specific ideas about supervisory functions and roles associated with these. You will have already considered some of these as a supervisee in Study Guide 1. For example:

- The organisational policy and documentation to be used relating to clinical supervision
- Professional guidelines and standards
- Formal and informal conversations as a practitioner with working clinical supervisors and your line manager
- The experience of being in clinical supervision as a supervisee
- The literature on clinical supervision, including Proctor's Interactive Model of Supervision (Proctor 1986)
- Study days or courses you might have attended.

Whilst organisational policies on clinical supervision will outline what is expected in practice, including the roles of all parties involved in the process and approaches to be taken, it will also clearly illustrate the organisational values ascribed to clinical supervision or the context in which clinical supervision will happen in everyday practice. Cottrell (2002), in a seminal paper, outlines some of the complex relationships between the organisation, managers and the roles of the supervisor and supervisee that can emerge when there is a lack of discussion or understanding about its implementation, resulting in what he describes as suspicion, resistance, tokenism and mutinous behaviours. A clear message when ascertaining the role of the new clinical supervisor is the need to also take

account of what the organisation perceives clinical supervision to be. In turn, this may then cause a division between clinical supervision policy and what happens in practice (Davey et. al 2006).

Not surprisingly, organisational policies, whilst outlining the role of parties engaging in clinical supervision, are also practical resources that necessarily move clinical supervision from the 'ideal' to the 'real', taking into account the fact that there is not a clear definition of clinical supervision that will fit all organisations (nor likely to be), but rather principles to work within. In the absence of a clearly defined clinical supervision for all nursing practice, it is not unusual for organisational policies to begin with what clinical supervision 'is not' and this is a useful starting point for new clinical supervisors when considering their role. The Royal College of Nursing (1999) in their guidance on clinical supervision also state, for example, that it is 'not' a management tool, a method of surveillance, or a hierarchical process.



Activity 3

1 hour

As part of the preparation for your first clinical supervision meeting with your peer colleague from practice:

- a Identify from your organisational policy or line manager what the role and responsibilities of the supervisor are likely to be in practice and compare these to what you consider clinical supervision to be based on being a supervisee in Study Guide 1.

- b From the identified role of a clinical supervisor within your organisational policy, note any skills that you will need to develop further (either as training or from your own clinical supervision) and those you think might be transferable from what you already do in practice.

Feedback for this activity is given at the end of the study guide

One of the challenges of introducing clinical supervision into everyday practice is that there needs to be a framework for clinical supervisors that is comprehensive enough to straddle the many different specialities in nursing, whilst at the same time not being so complex that it cannot be used (Driscoll 2000a page50). *Proctor's Interactive Model of Supervision* (Proctor 1986), outlined in Study Guide 1, is currently one of the most widely used frameworks for clinical supervision in practice (Sloan & Watson 2002, Winstanley & White 2003). It offers a practical framework and an aide memoire relating to the role and function of the clinical supervisor and at least three different ways of viewing the supervisee's account from practice. The three elements or functions, whilst in theory are equally applicable in the clinical supervision encounters, in reality tend to overlap or compete because there can be different strands within a supervisee's account from practice (Figure 2.1).

It is also possible that a clinical supervisor, based on their own experience of working in practice, might either consciously (or unconsciously) attempt to navigate the clinical supervisee's account into their own preferred areas of knowledge about practice (Hughes & Pengelly 1997). A way of avoiding this is to simply ask the supervisee after they have given an account from practice in clinical supervision which area they would like to focus on during the meeting! You might wish to think about your previous meetings as a supervisee in Study Guide 1 and whether your clinical supervisor demonstrated a preferred role or function, and the implications of this as you begin practising as a new clinical supervisor. Perhaps as you are offering clinical supervision to a peer colleague, a natural emphasis or role function you might consider as a new clinical supervisor is to be more supportive, rather than focusing on the accountability elements or learning possibilities of the supervisee's account from practice.

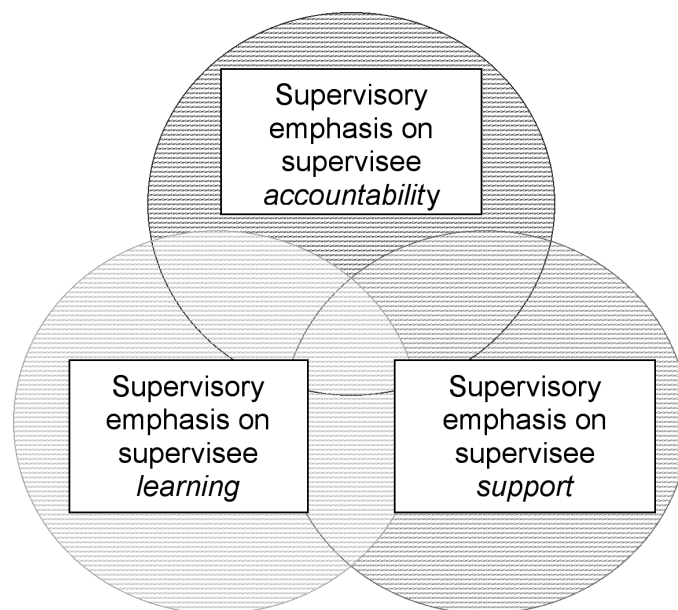


Figure 2.1 Clinical supervisor roles based on Proctor's Interactive Model of Supervision (1986)

- The Formative Function (Emphasis on Learning) – clinical supervision concerned with the continued development of the skills, abilities and understandings of the supervisee/practitioner through regular reflection on practice of working in the healthcare environment
- The Restorative Function (Emphasis on Support) – clinical supervision concerned with how the supervisee/practitioner responds emotionally to the stresses and demands of working in the healthcare environment
- The Normative Function (Emphasis on Accountability) – clinical supervision concerned with maintaining and monitoring the effectiveness of the supervisee/practitioner's everyday healthcare work.

Creating the Climate in which Effective Clinical Supervision can Happen

Whilst this section so far has tended to focus on the more tangible or observable roles of the new clinical supervisor, there is a growing body of evidence supporting that idea that the personal characteristics of the individual clinical supervisor can form the basis for an effective working relationship in clinical supervision (Arvidson & Fridlund 2005, Fowler 1995, Hawkins & Shohet 2000:118, Sloan 2006:29, 1999, Williamson & Harvey 2001:152). Some of the key characteristics for an effective clinical supervision relationship include:

- An ability to provide a supportive relationship
- Being able to separate the clinical supervisory role from their work roles
- Being approachable
- Being open and honest
- Being non judgemental
- Having credible knowledge, experience and skills in clinical practice
- Being a role model by demonstrating a commitment to clinical supervision and the supervisee and themselves being a supervisee.

Whilst it might be argued that some of these supervisory traits are innate, some of these can more obviously be located within the repertoire of a counsellor or therapist and therefore are able to be learned with practice and feedback over time. Whilst clinical supervision is not a form of therapy, there is no reason why some of the interpersonal and communications skills used in those other disciplines cannot be considered as useful for the new supervisor. It is also likely that supervisees may themselves come to clinical supervision with a basic, if not advanced, sense of how to communicate, as it is a central part of any modern nursing curriculum. Jean Faugier (1988 p32), in the relationship component of her 'growth and support' model of clinical supervision, warns the supervisor against letting the supervisee divert the clinical supervision meeting into one where personal needs become the centre of attention instead of clinical practice.

Other more specific skills that were seen as important, and ones that, as a new clinical supervisor, you may already have experience in or will need to work towards, are:

- Being a good listener
- The ability to facilitate reflection in others through the use of guided questioning
- Being able to help the supervisee in summarising a clinical supervision meeting
- Being able to challenge as well as support the supervisee
- Being able to offer effective feedback.

A key characteristic for any clinical supervisor would seem to be having the ability to provide a supportive relationship in which clinical supervision can happen. Whilst the practicalities of getting an agreement or contracting with the supervisee are discussed later in this study guide, it would seem that the clinical supervisor has a direct responsibility for creating the environment in which clinical supervision can happen. This does not simply mean ensuring an appropriate physical environment, but also a psychological space in which to reflect on significant aspects of practice.



Activity 4

3 hours

In preparation for beginning to supervise a peer colleague in practice:

- a** Reflect on some of the roles, characteristics and skills previously described for becoming an effective clinical supervisor. How would you rate your own potential as a new clinical supervisor?

- b** Based on your responses to part a), what will be priority areas for you to develop as a new clinical supervisor and what would need to happen?

Continued

c With reference to the accompanying CD-ROM in which the clinical supervisor has a responsibility to create a suitable environment for clinical supervision, write short notes on the following:

- Creating a safe environment for clinical supervision to happen

- Removing barriers to effective clinical supervision

- Ways in which an open and honest clinical supervision relationship can be fostered

- How equality in the clinical supervision relationship can be promoted.

Feedback for this activity is given at the end of the study guide



At this stage of your studies you should have obtained information about getting started in clinical supervision and should have arranged a date and time for your first clinical supervision meeting with a peer colleague.

Having undertaken the reading and activities in this section, it is useful to review some key points before progressing on to the next stage of Study Guide 2. The next section will help you to prepare for the first clinical supervision meeting as a new clinical supervisor and offer a basic structure for ongoing meetings.



Key Points

- Being a supervisee in practice prior to becoming a clinical supervisor means you are likely to have developed a working knowledge of clinical supervision.
 - Giving and receiving feedback on practice is a fundamental purpose of clinical supervision.
 - The personal and professional demands of being a clinical supervisor require ongoing organisational support.
 - Organisational policies on clinical supervision should reflect shared managerial and practitioner values.
 - For new clinical supervisors it can be useful to think of what clinical supervision 'is not' in the absence of a clear definition for practice.
 - The clinical supervisor's work expertise may lead to a narrow examination of the supervisee account from practice.
 - Effective clinical supervision can be dependent on the personal characteristics of the supervisor, therefore self-awareness skills are just as important as supervisory skills.
 - The clinical supervisor has a direct responsibility for creating the environment in which clinical supervision will happen.
-

3 Preparing to Supervise Clinical Supervision Meetings

The main aims of this section are to:

- consider the influence of managerial supervision in relation to clinical supervision
- analyse different supervisory intervention styles available to the clinical supervisor in a clinical supervision meeting
- reflect on the key issues to address with a supervisee in getting agreement for what will happen in clinical supervision
- examine the component parts of a clinical supervision meeting beyond the first meeting
- reflect on ways to structure a clinical supervision meeting that meets the needs of the supervisee as well as the supervisor.



Guided Reading

- Heron, J. (2001). *Helping the Client: A Creative Practical Guide*. (5th edn.) Sage, London.

Consider in detail each of the six intervention categories used in a counselling situation and reflect on their applicability to use as a clinical supervisor (Learning Outcomes 3, 4 & 5)

- Power, S. Chapter 3: Boundaries and responsibilities in clinical supervision in: Driscoll, J. (ed.)(2007) *Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals* (2nd edn) Bailliere Tindall, Elsevier, Edinburgh, UK, pages 53-71.

Consider what boundaries are important to discuss as a clinical supervisor in the first clinical supervision meeting with a supervisee (Learning Outcomes 3, 4 & 5)

- Sloan, G. Watson, H. (2001) 'John Heron's six-category intervention analysis: towards understanding interpersonal relations and progressing the delivery of clinical supervision for mental health nursing in the United Kingdom *Journal of Advanced Nursing* 36(2): 206-214.

Analyse from a research perspective the potential of Heron's (1975) six intervention categories in the clinical supervision situation (Learning Outcomes 3, 4 & 5)

Supervisory Approaches and Styles

It might already be becoming apparent that the role of the clinical supervisor and the delivery of effective clinical supervision is a complex business. At first, new clinical supervisors may feel quite overwhelmed, but perhaps on reflection it is about transferring some of the skills you will already have learnt from practice and adjusting these to fit in with the intentions of clinical supervision in practice. As a supervisee you will already have a working knowledge of what happens in clinical supervision and this section will build on this work from the perspective of a clinical supervisor.

Each clinical supervision relationship and meetings are unique, as both parties will take into the supervision meeting their own perspectives, knowledge, skills and experience. As alluded to in the previous section, both the clinical supervisor and the supervisee will be, to some extent, products of the organisational culture in which they work. Therefore it is likely that, for those new to clinical supervision, the approaches adopted will initially be based on previous training, policies and guidelines, as well as personal role experience and preferences.

One of the immediate challenges as a new clinical supervisor is to be aware of how clinical supervision differs significantly from managerial supervision. Whilst this might seem obvious at first glance, it is likely that our own experiences of being supervised in practice as learners, the way we then manage our clinical practice, and of course how then we are managed ourselves within the organisation, may significantly influence how clinical supervision is then practised. For instance, due to a shortage of clinical supervisors you might find yourself being offered clinical supervision by your line manager. This raises interesting questions about whether managers can really be clinical supervisors and who the supervisors should actually be. Conversely, even if managers do actively support the development of clinical supervision within the organisation for practitioners, a low uptake by staff might then be suggestive that clinical supervision (and therefore clinical supervisors), is viewed as a form of surveillance. Clearly, supervision histories and experiences within the organisational culture will also contribute to the delivery of clinical supervision in practice.



Activity 5

1 hour

In relation to you becoming a new clinical supervisor, what in your opinion makes clinical supervision distinguishable from more managerial forms of supervision in practice?

Feedback for this activity is given at the end of the study guide

John Heron's (1975) six-category intervention analysis was a model originally developed in order to understand how a practitioner interacted with a client in the counselling situation, and which is now widely used in interpersonal training across a range of professional disciplines. Heron (2001:p3) describes an intervention as an identifiable piece of verbal and (or), non verbal behaviour that a professional might use in the helping situation. Its usefulness in the development of clinical supervisor training is because each of the six interventions (or categories) is directly observable and because non-verbal behaviour can be just as critical in determining how the verbal behaviour or message comes across. The six categories of interventions might also be seen as supervisory styles to which a clinical supervisor might respond with a supervisee. They can be sub-divided into two main groupings, either authoritative or facilitative interventions (Figure 2.2).

Figure 2.2

SIX supervisory styles or interventions available to the clinical supervisor in a clinical supervision meeting

AUTHORITATIVE INTERVENTIONS	FACILITATIVE INTERVENTIONS
<i>Prescriptive: directs behaviour</i> giving advice, making suggestions –‘should-ing’	<i>Cathartic: space for feelings</i> encouraging the expression of emotions
<i>Informative: imparting knowledge</i> offering information	<i>Catalytic: problem solving</i> drawing issues out and getting below the surface dialogue
<i>Confronting: directly challenging</i> raising awareness of a limiting attitude or behaviour	<i>Supportive: encouraging</i> affirming the worth of the individual – non-judgemental

You might think that, at first glance, authoritative interventions and facilitative interventions are helpful in differentiating between managerial forms of supervision and clinical supervision. However, it is important to stress that all six interventions are open to the clinical supervisor to use and no single one is any better than the others (Sloan & Watson 2001).

All six-category interventions present an observable classification of communication patterns in order to discover any preferred style of the supervisor. In reality, a clinical supervisor is likely to move between the six category interventions depending on their intentions with the supervisee during a clinical supervision meeting. As a tool in clinical supervisor training, in which the use of role play and being observed by peers is used, the six- category is a useful tool when offering feedback and discussing other options that might have been used with the supervisee.



Activity 6

3 hours

- a** Based on your reflective notes and recalling previous clinical supervision meetings completed in Study Guide 1, what seemed to be the preferred six-category intervention styles of your clinical supervisor?

- b** Later in Study Guide 2, when you are acting as a clinical supervisor to a peer colleague, obtain permission for at least ONE of those 4-6 meetings to be observed by your own clinical supervisor (or alternatively tape record the meeting), so that you can obtain some feedback on your intervention styles with your supervisee.

Feedback for this activity is given at the end of the study

Issues in Getting Agreement in the First Meeting(s)

At this stage of your studies you will be organising yourself around the date agreed for the first of 4- 6 clinical supervision meetings with a peer colleague. In addition to this, you will also have prearranged your first meeting with your own clinical supervisor who has agreed to supervise you on your clinical supervision throughout this study guide. This may simply be a continuance of the clinical supervision you received in Study Guide 1, although the focus for these meetings will now be different.

You will have already had direct experience of what to expect in the first (contractual) meeting and follow up activities as a supervisee in Study Guide 1. A key difference in getting an agreement in the first clinical supervision meeting will be that you will now be responsible for guiding that conversation with your peer colleague as a clinical supervisor in practice. You may wish to refer to your organisational policy reminding yourself of the roles and responsibilities of the clinical supervisor in practice and examine the chapter by Power (2007) in the reading list. Reminding yourself about what will need to be included in the contract and the ongoing documentation to be used is a good way of getting you started with your first clinical supervision meeting.



Activity 7

1 hour

Based on your own reading and the organisational policy or guidelines on clinical supervision, brief yourself on the following:

- a** The responsibilities of the clinical supervisor in practice.

- b** The shared responsibilities you might have in clinical supervision as clinical supervisor and supervisee.

- c** What will need to happen in the event of the clinical supervisory relationship breaking down.

Feedback for this activity is given at the end of the study guide

The key issues that will need to be discussed as part of the clinical supervision contract can be summarised as:

- Understanding the purpose of clinical supervision and what it is not
- Agreeing practical aspects such as dates, frequency, duration, venues, contact points, arrangements for cancelling meetings, etc.
- Clarifying roles and responsibilities of both the supervisee and supervisor
- Agreeing on methods of documentation and how confidentiality will be maintained
- How the meetings will be organised beyond the first meeting.

Whilst more specific issues relating to confidentiality (Cutcliffe et.al.1988) and record keeping in clinical supervision can be found elsewhere (Cutcliffe 2000), it is important not to neglect these discussions when there seems so many other things to talk about in the first meeting. The first meeting in clinical supervision is often quite structured but helpful in gaining confidence as a new clinical supervisor because laying the ground rules

- b** (Optionally) Devise an A4 sheet, which could be used as a prompt by yourself as a clinical supervisor, that contains the key headings for each of the FIVE stages and include some key questions you might use during a clinical supervision meeting with your peer colleague.

Feedback for this activity is given at the end of the study guide

The responsibility for managing the time in, and maintaining a structure of, a meeting lies with the clinical supervisor. This is because he / she is more likely to be able to take a detached approach to what are often emotive issues raised by the supervisee in clinical supervision and pay more attention to time. Any clinical supervision meeting structure, regardless of the model or framework used, will inevitably need to contain time for:

- settling in
- clarifying what the supervisee wishes to discuss
- discussing the issue
- agreeing what might need to happen for next time
- closing the meeting by summarising the key points
- a brief comment on the effectiveness of the meeting
- confirming when and where the next meeting will be held.

As best practice in clinical supervision (Butterworth et.al 1997, Winstanley and White 2003) it is worth considering that, for clinical supervision meetings to be effective, they work best when they are between 45-60 minutes in duration and held on either a monthly or bi-monthly basis. In addition, clinical supervision is more positively evaluated if the supervisee is able to choose their own supervisor and when meetings are held away from the workplace (Edwards et.al. 2005).



At this stage of your studies you will now be beyond the first clinical supervision meeting stage with your peer colleague AND with your own clinical supervision as a supervisee to aid in supporting you through the process.

Having undertaken the reading and activities in this section, it is useful to review some key points before progressing on to the next stage of Study Guide 2. The next section will help you to develop more of a critical awareness of different supervisory models and approaches available to you as a clinical supervisor in practice.



Key Points

- The role of the clinical supervisor and the effective delivery of clinical supervision is complex.
 - Clinical supervision requires having a shared awareness of the intentions behind meetings as the clinical supervisor and the supervisee.
 - It is important to be able to distinguish clinical supervision from managerial forms of clinical supervision.
 - John Heron's (1975) six category interventions offer a broad range of communication choices or supervisory styles to the clinical supervisor in a clinical supervision meeting.
 - The main difference between contracting in clinical supervision as a supervisee and being a clinical supervisor is that the latter acts as a guide to the process.
 - Confidentiality and record keeping are often major concerns for the new supervisee in clinical supervision, it is therefore important that this is covered in the first meeting.
 - The structure of a clinical supervision meeting will depend on the model agreed with the supervisee but it is likely that both parties will be able in the first instance to relate to the structure of reflective practice.
 - The responsibility for facilitating a clinical supervision meeting lies with the supervisor.
 - Best practice for clinical supervision meetings are that they are held every 4-8 weeks, last for an hour or more and are held away from the workplace.
-



Progress Check 1

Based on your reading and completion of the activities in this section, answer the following questions:

- 1 In what ways can having an organisational policy on clinical supervision support a working clinical supervisor?

- 2 How might peer supervision differ from other forms of clinical supervision?

- 3 How might continuing to be a supervisee in Study Guide 2 support you in your development as a working clinical supervisor?

- 4 What are some of the key issues to consider as a clinical supervisor in relation to documentation in clinical supervision?

Check your answers with those at the end of the study guide.

4 Supervisory Models and Approaches in Clinical Supervision Meetings

The main aims of this section are to:

- briefly review some supervisory models or approaches that can increase the range of options for clinical supervisors when working with supervisees
- examine different psychological approaches that can be used in clinical supervision as a new clinical supervisor
- consider alternative approaches as a clinical supervisor in dealing with supervisee 'problems' that can so often feature in a clinical supervision meeting
- examine ways in which having an awareness of the developmental stages of clinical supervision can contribute to the effectiveness of clinical supervision meetings.



Guided Reading

- Hawkins, P. Shohet, R. (2000) *Supervision in the helping professions* (2nd edn), Open University Press, Buckingham, UK, (Chapter 5: Maps and models of supervision), pages 49 – 66.

Reflect on what sorts of skills might be necessary to develop your own framework or approach for supervision as a new clinical supervisor (Learning Outcomes 1, 3, 4 & 5)

- Lowe, R. Guy, G. Chapter 12 *Solution orientated inquiry for ongoing supervision: expanding the horizon of change* in: McMahon, M. Patton, W. (eds.) (2002) *Supervision in the helping professions: a practical approach* Prentice Hall, Frenchs Forest, New South Wales, Australia, pages 143 – 156.

Reflect on a challenge to more problem orientated approaches to clinical supervision (Learning Outcomes 3, 4 & 5)

- Sloan, G. Chapter 5: *Psychological approaches to the clinical supervision encounter* in: Driscoll, J. (ed.) (2007) *Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals* (2nd edn) Bailliere Tindall, Elsevier, Edinburgh, UK, pages 95 -118.

A rationale for adopting a psychological perspective on clinical supervision in nursing without the need to be a therapist (Learning Outcomes 3, 4 & 5)

Continued

- Van Ooijen, E. (2003) *Clinical Supervision Made Easy* Churchill Livingstone, Edinburgh, UK, (Chapter 1 *Models of Supervision*) pp13 – 32.

A very readable classification of clinical supervision models that can increase the range of options open to a supervisor new to clinical supervision (Learning Outcomes 3, 4 & 5)

An Overview of Different Models of Clinical Supervision

Power (2007 p58) rightly states that, in setting boundaries in clinical supervision, the clinical supervisor needs to question themselves about whether he / she is up to the task of offering the supervisee what they are expecting to get from supervision. Not unusually, a supervisee when agreeing a clinical supervision contract might enquire whether the clinical supervisor has the appropriate clinical experience and professional background to match their own expectations of clinical supervision. You might also question what particular expertise or theoretical orientation you take into the clinical supervision room, as it is unlikely that just one style will fit every supervisee you are likely to meet.

Looking back over both study guides it could be argued that you already have some theoretical frameworks or models to guide you as a clinical supervisor for instance, facilitating reflective practice, using a preferred communication style based on Heron's (1986) framework or through having a working knowledge of the task and functions of clinical supervision outlined by Proctor (1986). Van Ooijen (2003) suggests that models of clinical supervision can help the supervisor clarify not just what is done but can offer guidance on how it is done. This helps to avoid concerns expressed by Heath and Freshwater (2000) about clinical supervisors having inappropriate supervisory intentions, e.g. being 'in charge' of the meeting and focusing on personal issues at the expense of what happens with the supervisee's patients / clients.

Perhaps the most recognisable of these is models of reflection, outlined in Study Guide 1, and your first exposure to this was likely to have been as a student in an educational setting. Here the purpose of reflection would have been the importance of being able to describe significant experiences and analysing these with the intention of learning and improving upon practice. Reflection is described as the method or process of going about reflection, and reflective practice as it then applies to the health professional in their work setting (Driscoll 2007b page27). The implications of this model for the new clinical supervisor is in being able to use the tools or methods available to guide the supervisee, with an emphasis on learning and supporting the development of practice (two of Proctor's (1986) functions of clinical supervision). A further emphasis is placed on the clinical supervisor to commit to reflection on their own (supervisory) practice with an experienced clinical supervisor, not unlike other helping related disciplines. This is why it is important to continue to be a supervisee to complete this study guide.

Most psychological models or approaches in clinical supervision, not surprisingly, are attributed to disciplines such as counselling, clinical psychology and psychotherapy. Students throughout their training in these disciplines are orientated to a particular theoretical framework or approach which, once qualified, continues to form the basis of their clinical supervision in practice, e.g. a cognitive behavioural therapist (CBT) will often supervise and role model a way of working with their supervisee using a CBT method or approach. (For a fuller discussion on this approach see Sloan 2007, page99).

It could be argued that adopting a psychological approach in clinical supervision can offer you as the supervisor a wider lens from which to view the supervisee. Hawkins & Shohet (2000 page 69) describe FOUR elements that are present in all clinical supervision meetings:

- clinical supervisor
- clinical supervisee
- patient/client
- work context.

From this there are at least TWO interlocking supervisory systems (or what Hawkins & Shohet refer to as 'matrices') that might be considered by the clinical supervisor:

- The work context matrix: between the supervisee and their patients / clients in the practice setting
- The supervision matrix: between the supervisee and the supervisor in the supervision room.

The focus for the work content matrix has also been described by Driscoll (2000 page 124) as 'looking at the past to see future practice' and is not dissimilar to reflecting on practice situations with the supervisee. The focus for the supervision matrix is described as 'looking at the present to see future practice' in that the sorts of interactions that happen between the supervisee and the supervisor in the supervision room could also mirror the relationship between the supervisee and his / her patients or clients. This is a term often referred to as a 'parallel process' and occurs at an unconscious level by the supervisee. A more detailed analysis of unconscious processes that can happen in clinical supervision can also be found in Playle & Mullarkey (1998).

Although the supervision matrix is often used by disciplines such as counselling, clinical psychology and psychotherapy, a psychological approach might offer new ways of seeing clinical supervision as a clinical supervisor, provided that clinical supervision does not then become therapy for the supervisee (Yegdich 1998).



Activity 9

1.5 hours

Write brief notes on the following:

- a** Based on the scenarios contained in the accompanying CD-ROM, identify at least ONE supervisee that might have benefited from the clinical supervisor using a psychological approach in clinical supervision and outline your reasons for this.

- b** Based on your guided reading and own experience in clinical supervision, what do you consider to be some basic psychological skills that might be helpful to develop as a new clinical supervisor?

- c** How do you think the use of psychological skills as a clinical supervisor might differ from that of being a therapist?

Feedback for this activity is given at the end of the study guide



At this stage of your studies you will now be offering regular clinical supervision meetings with your peer colleague, as well as engaging in your own clinical supervision to do with working as a new clinical supervisor.

Moving from Finding Problems to Finding Solutions in Clinical Supervision

It is interesting to reflect on how the influence of 'problems' in a healthcare setting is all around and even part of the everyday working culture, e.g. working with patient / client problems would seem important in working out how to then diagnose and treat the person in the future. However, it might also leave that patient / client feeling dependent on staff to solve the 'problem' for them, as they seem to have more knowledge or experience. Having a working knowledge of patient / client 'problems' as a nurse, whilst seemingly intrinsic to practice, can also transfer into the clinical supervision situation, as being helpful will often mean intervening on behalf of the person in care. For instance, the inexperienced clinical supervisor might think that they should be expected to intervene to help solve the supervisee's 'problems' from practice during a meeting. In doing so (intervening), this might be viewed by clinical supervisees (and managers) as one of the characteristics of a 'good' supervisor because 'problems' then get solved (but, by the clinical supervisor) in clinical supervision. One of the consequences of this can be that, rather than 'enabling' the supervisee in practice, they then become 'disabled' by an over enthusiastic supervisor to intervene in areas in which they have greater experience or knowledge in practice. One of the ways in which having a working knowledge of different psychological approaches and theories can be helpful as a clinical supervisor is by encouraging the supervisee to move from 'my problem in supervision today is...' to fostering a more solution orientated or strengths based approach to the clinical supervision meeting.

Solution Focused Therapy (SFT) is an alternative approach to the 'problems' of the medical model of psychiatry and psychotherapy (Hawkes et.al. 1993) founded on the work of de Shazer (1985). This approach emerged through noticing that clients in therapy could be helped just as effectively by engaging in talk about their future as by emphasising their problem laden past (Sloan 2007 p110). Some of the principles of SFT have since been described by others as a useful method for challenging 'problem' based clinical supervision (Driscoll 2000b, Edwards & Chen 1999, Lowe & Guy 2002). You may wish to follow up on the references to gain a deeper understanding of SFT approaches, questions used and meeting structures you can use as a clinical supervisor. However, some of the key principles would already seem to parallel the principles of clinical supervision and offer a potential structure for a meeting:

- The agenda for the meeting is determined by the supervisee
- Goals to work towards are agreed at the beginning of the meeting
- Some goals may need to be reviewed depending on their complexity
- Supervisee strengths are identified and highlighted in the meeting
- There will always be times when the supervisee is not experiencing 'the problem' (exceptions) and is already contributing to part of their own solution
- Supervisor actively appreciates supervisee strengths to reinforce doing more of what already works in practice
- Change is anticipated, talked about and actions expected as a result of the meeting

- The supervisee is accountable for what they agreed to do as well as not to do following the meeting
- The next meeting begins with the supervisee’s account of what happened (or not), based on the joint tasks set in the previous meeting.

When thinking about your own experiences to date as a supervisee, you may have already found that the way of working between you and the clinical supervisor not unnaturally focuses on the ‘problems’ from practice and perhaps implicitly, rather than explicitly, is also reflected in some working definitions of clinical supervision. Perhaps there are implications for both the supervisor and clinical supervisee in their approaches to using practice ‘problems’ as the focus for clinical supervision. For instance, the Nursing and Midwifery Council in their advice on clinical supervision (NMC 2006) state that clinical supervision should enable nurses to be able to ‘identify solutions to problems’.



Activity 10

1 hour

Based on your own reading, experience in clinical supervision and having previously completed Activity 8, what might be some of the similarities and differences between structuring a clinical supervision meeting and adopting a more solution focused structure for you as a clinical supervisor?

Feedback for this activity is given at the end of the study guide

It is very likely that what is spoken about in clinical supervision and how this is then handled with the clinical supervisor may also reflect the different stages of development that the supervisee (and the supervisor) is at.

The Developmental Nature of Clinical Supervision

It might be argued that the developmental nature of clinical supervision is an appropriate metaphor (and framework) for nursing because, for many participants whether as a clinical supervisor and (or) supervisee, it will still be regarded as a new activity for practice. Developmental models of clinical supervision are influenced by developmental psychology and focus mainly (but not exclusively) on the developmental or educative function of supervision (van Ooijen 2003 page 20). Therefore, the emphasis is on the different stages of learning and trying to match the type of clinical supervision offered by the clinical supervisor to the developmental stage of the supervisee.

Rafferty & Colman (2001 page 93) state, if clinical supervision is to be considered a career-long concept in clinical practice then it is important that it should not be a 'one stop shop' but reflect the developmental needs of the practitioner / supervisee in relation to their career journey from novice to expert (Benner 1984 pages 13-34). The implications of this are that for clinical supervision to be effective, the clinical supervisor must then be able to meet supervisee expectations based on having a working knowledge and experience of the supervisee's developmental stage in practice. This raises the question of whether the supervisor should have more clinical experience than the supervisee (unlike offering supervision to a peer colleague) or, whether it is possible to work as a clinical supervisor without having a working knowledge of the supervisee's practice.

In addition to the career stage of the supervisee, the stages of the clinical supervision relationship can also be examined. This is not just a way of understanding the relationship itself in a psychological sense, but as a reminder that the quality of the clinical supervision relationship, as Kilminster & Jolly (2000) assert, is probably the single most factor for the effectiveness of clinical supervision. Therefore, having a working knowledge of the different stages of the relationship can indicate not just the potential for clinical supervision, but areas that may need to be worked on with the supervisee.

Dolley et.al (1988) outline FIVE stages of a clinical supervisory relationship that develop over time (Figure 2.3).

Stages (in descending order)	Characteristics of the supervisory relationship
Dependence	In this early stage of the relationship the supervisee relies heavily on the expertise of the supervisor. This can be particularly so if the relationship outside clinical supervision is hierarchical or managerial in nature.
Confrontation	A disagreeing phase where differences begin to emerge, challenging the dependent relationship. To move on from what is a healthy stage requires an acceptance that differences exist, rather than feel personally hurt when confrontation occurs.
Independence	Asserting and accepting the differences that there are can give rise to a more confident supervisee, although there might also be difficulties in 'letting go' by the supervisor.
Co-operation	Both parties are more aware of each other's strengths and weaknesses and more able to see clinical supervision as a joint venture to enhance care as well as the organisation. The supervisee can now more fully work with the supervisor to resolve concerns about their clinical practice.
Collaboration	Both recognise each other's specific contribution to practice through clinical supervision and can safely confront and mutually learn from each other. It may be difficult as an observer to know who is supervising who!. An ideal situation from this positive relationship would be considering how to continue this collaborative relationship outside clinical supervision with other members of the team, e.g. peer supervision.

Figure 2.3: Stages of a clinical supervision relationship



Activity 11

2 hours

- a** Based on your experience as a clinical supervisor, consider what developmental stage of the clinical supervision relationship you are currently placed with your peer supervisee, based on the descriptions in Figure 2.3.

- b** What changes might need to take place in order for the clinical supervision relationship to move into the next development phase of the relationship? What needs to happen (if anything)?

- c** Take along your responses to Activity 11 to discuss with your clinical supervisor at your next clinical supervision meeting to see if he /she agrees with your assessment of the clinical supervision relationship.

Feedback for this activity is given at the end of the study guide

It is highly unlikely, as a new clinical supervisor, that you will adopt any single model from the different supervisory frameworks outlined in this section and will instead consider a more eclectic approach to develop your own style of clinical supervision. Being able to be flexible and adapt your style will be useful in relation to the different needs of supervisees you will meet in practice beyond the 4-6 meetings with a peer colleague that is part of the requirement for this study guide. It is also important that you periodically consider your own intentions as a new clinical supervisor, as well as the general goals of clinical supervision itself. Being willing to receive feedback by the supervisee will help to gain confidence and develop your own style over time.

Although some of the frameworks and models outlined for working as a clinical supervisor have been influenced by the psychological literature, how possible is it to not have a theoretical basis for your role as a clinical supervisor? In other words, could clinical supervision simply operate in clinical practice without a theory? Perhaps rather than being

influenced by the literature from other disciplines, nursing needs to consider its own theories of human nature, caring and communicating effectively with patients / clients as forming the basis for being a clinical supervisor? Posing questions such as these, rather than just being accepting of ways of working as a clinical supervisor, is one of the ways in which clinical supervision can be monitored and evaluated and is the subject of the next section in Study Guide 2.



Key Points

- When setting boundaries in clinical supervision, the clinical supervisor will need to question their own intentions with the supervisee and on what theoretical basis (if any) they will offer clinical supervision.
 - Reflective practice is an easily recognisable approach in clinical supervision.
 - The clinical supervisor will need to commit to the process of reflection (on supervisory practice) as well as the supervisee in clinical supervision.
 - Psychological models and frameworks for clinical supervision originated from psychotherapy, counselling and clinical psychology training and, once qualified, these models tend to inform the supervisory practice or approach.
 - Using psychological approaches can help widen the supervisor perspective when working with the supervisee in clinical supervision and can be regarded as either 'looking at the past to see future practice' and (or), 'looking at the present to see future practice'.
 - When using psychological frameworks as a clinical supervisor it is important that meetings do not become therapy and supervisory intentions relate to the principles and context of clinical supervision.
 - Some of the principles of solution focused therapy parallel those of clinical supervision and can offer an alternative approach when discussing the problems of practice.
 - Psychological developmental models of supervision focus mainly on the educative function of clinical supervision.
 - Developmental approaches in clinical supervision can focus on the career stage of the supervisee as well as the different stages of the supervisory relationship.
 - It is likely that clinical supervisors in nursing will adopt an eclectic blend of approaches to match their own style of clinical supervision, along with the expectations of the supervisee.
-



Progress Check 2

Based on your reading and completion of the activities in this section, answer the following questions:

- 1 When using psychological approaches as a form of clinical supervision, how might the clinical supervisor guard against this becoming a form of therapy for the supervisee?

- 2 Based on your own experience as a clinical supervisor, how necessary is it to have a working knowledge of different models and approaches in clinical supervision when working with the supervisee?

Check your answers with those at the end of the study guide.

5 Monitoring the Effectiveness of Clinical Supervision

The main aims of this section are to:

- reflect on why it is important to monitor the effectiveness of clinical supervision
- consider why evaluating the effectiveness of clinical supervision presents a challenge in practice
- examine how the effectiveness of clinical supervision can be monitored when there are no professional standards from which to measure its effectiveness
- reflect on ways in which the process of clinical supervision can be evaluated through individual reflection and reporting on supervisory performance



Guided Reading

- Bishop, V. (*Chapter 6: Literature Review – Clinical Supervision Evaluation Studies*) in: Bishop, V. (2007) (ed.) *Clinical supervision in practice: some questions, answers and guidelines for professionals in health and social care* (2nd edn), Palgrave Macmillan, Basingstoke, UK, pages 141-158.

A detailed literature review examining some of the key studies in nursing evaluating clinical supervision in practice (Learning Outcomes 3, 4 & 5)

- Driscoll, J. (*Chapter 11: Monitoring the effectiveness of clinical supervision in practice: is the truth already out there?*) in: Driscoll, J. (2000) *Practising Clinical Supervision: A Reflective Approach* Bailliere Tindall (in association with the Royal College of Nursing), Elsevier, Edinburgh, UK, pages 177-194.

Examine some ideas for monitoring clinical supervision in practice (Learning Outcomes 3, 4 & 5)

- Rafferty, M. Llewellyn-Davies, B. Hewitt, J. (*Chapter 10: Setting standards for the practice of clinical supervision – a Welsh perspective*) in: Driscoll, J. (ed.) (2007) *Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals* (2nd edn) Bailliere Tindall, Elsevier, Edinburgh, UK, pages 217 -241.

A research based chapter outlining ways of evaluating nine standards in clinical supervision in Wales (Learning Outcomes 3, 4 & 5)

Continued

- Winstanley, J. White, E. (2003) 'Clinical supervision models and best practice' *Nurse Researcher* 10(4): 7-38.

A detailed paper outlining best practice in nursing clinical supervision and how this can be monitored

- Winstanley, J. (Chapter 15: *Developing methods for evaluating clinical supervision*) in: Cutcliffe, J, Butterworth, T. Proctor, B. (eds.) (2001) *Fundamental Themes in Clinical Supervision* Routledge, London, UK, pages 210-224.

A chapter outlining the current methods of evaluating clinical supervision by the author of the Manchester Clinical Supervision Scale (Learning Outcomes 3, 4 & 5)

Why is it Important to Monitor Clinical Supervision?

Whilst this section on monitoring the effectiveness of clinical supervision appears at the end of Study Guide 2, in reality, issues relating to the effectiveness of clinical supervision may have already been discussed as part of the first meeting. You may have even built in a review meeting as part of the clinical supervision agreement / contract. Monitoring will contribute to the overall evaluation of clinical supervision, as it invites participants to organise both formal and informal ways of examining the process by being directly involved in it. This might be before clinical supervision has taken place, during meetings, or reviewing its effectiveness (or not) after a number of agreed meetings. This becomes more challenging when you consider that the 'doing' of clinical supervision, particularly on a one-to-one basis, is often held behind closed doors, is viewed as confidential and that the knowledge for clinical supervision practice in nursing is still developing.

When tackling the question of whether clinical supervision in nursing practice might be effective, Bishop (2007 p142) states we also need to ask 'to whom' is clinical supervision effective, for example:

- The patient or client?
- The practitioner / supervisee?
- The practitioner / clinical supervisor (and as a supervisee)
- The employing organisation?
- The profession as a whole?

When asking that same question to different stakeholders, it is likely that there will be different ideas and priorities for evaluating the effectiveness of clinical supervision, e.g. the employing organisation might be concerned with strategic outcomes and implementation, whereas a clinical supervisor might be interested in their preparation and training or establishing a working relationship. Despite this diversity, there will be shared interests when evaluating the development of clinical supervision in practice:

- Clarifying the goals and purposes of clinical supervision in practice
- Weighing up the benefits and outcomes of those participating in clinical supervision in practice
- Observing and recording any changes in practitioners as a result of being engaged in clinical supervision
- Examining whether clinical supervision in practice has any direct impact on the delivery of patient / client care
- Identifying what constitutes good or poor clinical supervision practice
- Contributing to the debate about the knowledge needed for engaging in clinical supervision
- Providing evidence that the time spent in engaging in clinical supervision during work time is resource well spent by the organisation.

One of the current challenges faced in the development of clinical supervision in nursing is how to evaluate its effectiveness (Winstanley 2001 page 211). This is without any agreed professional standards against which to measure its effectiveness. Bishop (2007) outlines a range of large studies, which includes the development of the Manchester Clinical Supervision Scale (Winstanley 2000) building on a previous multi-site study in the UK (Butterworth et.al 1997). Both were outcome studies in which the tools used also incorporated Proctor's (1986) functions of clinical supervision, described earlier in this study guide, and have informed the development of a provisional standard in clinical supervision practice.

Setting Standards in Clinical Supervisory Practice

Rafferty et.al. (2007), in researching a provisional standard for clinical supervision for practitioners in Wales, outline nine standard statements that sit under Proctor's (1986) three functions of clinical supervision (Figure 2.4).

Professional Support (Restorative function)	Time: Giving commitment and honouring the time for the task	Environment: Securing a venue fit for the purpose in terms of comfort, privacy, absence of interruptions	Relationship: Establish a professional working relationship based on mutual trust
Learning From Practice (Formative function)	Focus: Attention is given to the expression of professional practice and reflection on its meaning	Knowledge: Search for meaning and gathering perspectives driven by empirical knowledge and experience from practice	Interventions: Affirm appropriate practice, support, professional esteem and offer achievable challenges to practice based on a secure relationship
Ensuring Reasoned Accountability (Normative function)	Organisational Support: Provides the necessary will and resources to enable clinical supervision	Recording: An agreement is reached about the minimum content of, ownership of, and access to, any records kept	Competency: Use of appropriate authority and recognition of personal and professional boundaries Support for supervisory practice and development

Figure 2.4

The provisional standards for clinical supervision in Wales

Each standard statement outlines the frame of reference and attempts to name the parts on which measurements can then be made. You might wish to consider whether the provisional standard for clinical supervision in Wales in Figure 2.4 accurately depicts some of the issues faced in your own experience of clinical supervision in practice. For instance, you might consider your own competency, interventions used and developing a working relationship with the supervisee as important elements in your role as a new clinical supervisor in practice. In most cases, the practice of clinical supervision will be enhanced by 'capturing significant experiences' through individual reflection and, as importantly, getting feedback from others who may be directly involved (e.g. your supervisee) or at an 'arms length' from the clinical supervision action (e.g. your own supervisor or line manager).



Activity 12

1 hour

- a** Based on your experience as a new clinical supervisor, identify which of the nine standard statements contained in Figure 2.4 presented the biggest challenges to you and consider ways in which these might be (were) overcome.

- b** Based on your experience as a clinical supervisee, identify which of the nine standard statements contained in Figure 2.4 presented the biggest challenges to you and consider ways in which these might be (were) overcome.

Feedback for this activity is given at the end of the study guide

Individual Reflection on Supervisory Performance

The collection of ideas contained in both study guides will be helpful in drawing together a collection of monitoring signposts for clinical supervision as part of your Summative Assessment. Much of your own monitoring of clinical supervision might have already happened without you being fully aware of it. You already have at least three perspectives on clinical supervision through undertaking this module:

- Clinical supervision from the 'outside looking in' – understanding its theoretical purpose and professional and organisational expectations from an observer point of view as a student.
- Clinical supervision from the 'inside' from a participant perspective in which you have experienced clinical supervision as an ongoing supervisee and as a new clinical supervisor in practice.

Based on your experiences, you have a unique view of clinical supervision that can contribute not just to your own continuing development in supervision and supporting others with theirs, but through direct experience, which can help shape the knowledge for its continued development in practice. At this stage of the module it will be useful to 'take stock' and make more sense of those supervisory experiences and begin to examine these against the theoretical literature as preparation for completing your Summative Assessment.

Further ideas for gathering that evidence (both theoretical and experiential) in developing the knowledge for clinical supervision might include:

- Examining the stated goals of clinical supervision in relation to organisational policies or guidelines and your own experiences
- Ways in which you have observed how clinical supervision is differentiated (or not), from other forms of supervision that happens in practice
- The written contract /agreement that was decided upon before starting out with clinical supervision
- Self-reporting of the expected role functions of the clinical supervisor as perceived by the supervisee, e.g. reflective notes, clinical supervision policies and documentation gathered during Study Guide 1
- Self-reporting of the expected role of the clinical supervisee as perceived by the clinical supervisor, e.g. reflective notes, clinical supervision policies and documentation gathered during Study Guide 2
- Joint reporting by the supervisee and clinical supervisor on the perceived effectiveness on the process of clinical supervision as a result of audio or visual recorded meetings (with consent), or verbal review meetings
- Formal and informal feedback on the effectiveness (or not) of the approach(es) or styles used by the clinical supervisor in clinical supervision by the supervisee
- Feedback on the effectiveness (or not) of your role as a new clinical supervisor from your own 'supervision on supervision'
- Reflection on the quality of the clinical supervision relationship. e.g. reflective notes, or supervision documentation

- Ways in which the supervisee reports that engaging in clinical supervision has contributed (or not) to their work in clinical practice
- Any formal evaluation on supervision practice.

Not unlike a clinical supervision meeting, breaking the structure down into its component (monitoring) parts can be less overwhelming than attempting to evaluate clinical supervision as a whole across the department or organisation.



At this stage of your studies it is anticipated you will now have undertaken all of your 4-6 clinical supervision with your peer colleague AND have been able to discuss aspects of your new role as a clinical supervisor with your own clinical supervisor. You might wish to close your studies by using the Summative Assignment to form the basis of a formal evaluation with your clinical supervisor and (or) supervisee on your experience of being a new clinical supervisor in practice.

Further reflective questions to address as part of monitoring your experience in clinical supervision during the module, and particularly in relation to your role as a new clinical supervisor, might be:

- What has been helpful to you being in clinical supervision?
- What was it about your clinical supervisor that helped you the most as a supervisee?
- In what ways might the philosophy or framework adopted by your clinical supervisor have influenced you as a new clinical supervisor?
- What has been some of your significant learning in clinical supervision as a practitioner, e.g. what challenges have you had to overcome?
- In what ways has your own experience of being a supervisee influenced your practice in your role as a new clinical supervisor?
- What do you consider your further development needs to be as a clinical supervisor, having completed the clinical supervision module?

Finally, whilst it has been argued that an outcome focus is valuable in the monitoring of clinical supervision, e.g. what happens as a result of being in clinical supervision, being able to capture the processes that also occur are of equal importance, but more challenging to quantify. The present climate in healthcare would seem to demand quantitative evidence and 'instant results' for supporting clinical supervision in what is often viewed as a time consuming activity alongside all the other 'must do's' in practice. However the 'task of doing', whilst important, also needs to be considered alongside what might be the outcome of failing to find adequate 'thinking time' for the process of clinical supervision in practice.



Key Points

- Developing strategies for monitoring the effectiveness of clinical supervision need to be agreed before the process starts.
 - One of the challenges of monitoring clinical supervision is that the process is confidential and often held behind closed doors.
 - When considering the outcomes of clinical supervision, it can be useful to ask 'to whom' it might be effective.
 - Evaluating clinical supervision is challenging when there are no professional standards against which its effectiveness can be measured.
 - A provisional standard for clinical supervision developed in Wales describes nine standard statements on which to evaluate its effectiveness based on Proctor's (1986) functions of clinical supervision.
 - The effectiveness of clinical supervision is reliant on capturing significant experiences and obtaining constructive feedback from others that are either directly or indirectly involved.
 - It is just as important to consider the ways of monitoring the effectiveness of clinical supervision in relation to its structure and processes as well as anticipated outcomes.
-

Summary of Study Guide 2

In this study guide you have been introduced to the role of a clinical supervisor, whilst at the same time remaining a supervisee and having 'supervisory support on your supervision'. The notion of the lifelong learner in clinical supervision applies equally to the supervisee as well as the supervisor. What has been attempted in both Study Guides is to run a parallel process of clinical supervision in which the best preparation for being a clinical supervisor is to also be a supervisee.

A key theme of this study guide has been to explore the understandings from the perspective of the new clinical supervisor, ways of getting started in clinical supervision and the associated roles and responsibilities for creating a suitable climate in which clinical supervision can happen, managing meetings and development of an 'intentional style or approach'. Such an approach is likely to be an eclectic mix of styles that doesn't just match supervisee expectations, but one within which the new clinical supervisor feels able to work but is likely to develop further as more experience is gained.

There has been a continued emphasis on developing the skills of reflection and to begin to more actively notice oneself in practice through the use of documentation as well as obtaining feedback from either the supervisee or your own clinical supervisor. Some of the additional challenges posed for the new clinical supervisor, in addition to the 'doing of' clinical supervision, are to consider ways of monitoring its effectiveness and develop the knowledge for practice.

Finally, in a literature review of 275 articles on clinical supervision, Chambers and Cutcliffe (2001) noted that these did not make any reference to 'ending' clinical supervision in their titles or key words. You might consider how you have ended your clinical supervision in practice as you come to the end of Study Guide 2. However, endings are significant, including the ending of this clinical supervision module – there needs to be an acknowledgement of the time you have invested in your studies and the commitment and energy with your new roles in clinical supervision. It might be that this ending is seen as just that, with the accompanying feelings of sadness and joy at completing the module. It might also be very possible that the end of your journey signifies a new road to travel in clinical supervision, with some additional bags full of new experiences and knowledge for that journey. What is clear is that the work of a clinical supervisor in practice can be seen as a continual journey of learning, rather than having a defined end point.

Formative Assessment Guidelines

Below are some guidelines that you should follow when submitting the formative assessment overleaf. Please read through this information carefully before you begin.

Submitting Your Formative Assessment

When your assessment is complete you should submit this to your tutor electronically, via the ICS student community. Please refer to your student handbook for detailed instructions on how to use the online submission facility.

Formative Assessment Cover Sheets

All assessments should begin with a formative assessment cover sheet. This can be downloaded from the ICS student community, and you should complete the appropriate fields and paste the cover sheet into the very beginning of your assessment document.

Naming Your File

You should save your document using the following format: Assessment Number Firstname Surname ICS Student Number. For example, 4002501 Helen Roddick 15378889

Assessment Checklist

Detailed instructions on submitting formative work can be found in your student handbook; these are summarised below. Please ensure that you have carried out the following checks before you submit your assessment. Failure to do so may result in your assessment being returned unmarked.

- Word process your work in Microsoft Word using black Times New Roman font at 12 point size (this is applicable to standard written work only, and not to tables/graphs/presentations etc)
 - Leave a good left hand margin
 - Include your name, student number and assessment number in the header of each page, and page numbers in the footer.
 - Use double line spacing
 - Include the title/question above your answer
 - Ensure your file is named appropriately (see guidelines above)
 - Reference all quotes using the Harvard referencing system, and include a reference list
 - Include a turnitin report (see your student handbook for details)
 - Save your work in Microsoft Word format (.doc)
 - Complete the formative cover sheet and paste this in at the beginning of your assessment document (see guidelines above).
 - Do not submit more than one formative assessment at the same time.
-



Formative Assessment 1

40358/01

Write a reflective essay of no more than 1500 words discussing what model or approach YOU might have taken as a clinical supervisor with any ONE of the supervisees in the accompanying CD-ROM. It is expected that you also bring in relevant theory where appropriate to support your discussion.

This assessment links to Learning Outcomes 3, 4 and 5.

Now send your answers to ICS.

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Useful Websites

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Feedback to Activities

Activity 1

It is likely to have been challenging at first while being a working supervisee in clinical supervision to then be able to see yourself in the role of a new clinical supervisor. As part of the contractual meeting there would have been some discussion on the expectations of both parties that would have differentiated the different roles and responsibilities as well as identifying any shared responsibilities, e.g. beginning on time, what to do if the meeting is cancelled, etc.

After the initial meetings it would be expected that the supervisee then takes more of a lead for describing and discussing a significant episode from practice and having a firmer idea of their intentions for recalling the event in clinical supervision. The supervisory role would have been likely to role model skills such as: paying attention to structuring the meeting; keeping to time; clarifying what was wanted from the meeting; questioning and summarising, whilst at the same time using a combination of challenge and support. It will have been interesting to consider who owned the clinical supervision (the supervisee or the clinical supervisor), who did the 'work' in clinical supervision and what outcomes emerged from the meetings.

Activity 2

The feedback you wished to offer your clinical supervisor will obviously depend on your experiences throughout Study Guide 1. You will also need to have considered what is meant by 'giving feedback' and how this is achieved before the meeting with your clinical supervisor. Perhaps a starting point may be to 'give feedback' on the way your clinical supervisor offered feedback to you in clinical supervision, e.g. how did it feel to be on the receiving end of that feedback and how did this compare to your reading on giving feedback?

The key to giving effective feedback is to be balanced in your approach, focusing on strengths as well as development needs. You will need to maintain a focus on the behaviours you witnessed as a supervisee in clinical supervision and how these might be improved, rather than focusing on the supervisor in a more generalised or personal way. You will also have noticed when giving feedback that to do so is dependent on the reaction of the person receiving it, e.g. did they expect it or did it come out of the blue? It might be argued that the supervisee expects to get feedback on their practice as part of clinical supervision. Finally, the person (in this case your clinical supervisor) would need to be willing to accept your feedback as part of their own learning. None of this is possible without the development of a safe and trusting environment in the clinical supervision situation.

Activity 3

The role of the clinical supervisor is usually outlined in some detail within an organisational policy and is likely to include some or all of the following:

- Ensuring privacy is available for meetings
- Recording attendance at the clinical supervision meetings
- Helping the supervisee explore and clarify their own thinking, feelings and beliefs about practice issues using guided reflection
- Giving clear and constructive feedback
- Sharing information, experiences and skills where appropriate
- Challenging practice issues raised in the meeting and supporting the supervisee to work on any development needs they might have
- Being aware of any organisational constraints upon the supervisee in practice
- Summarising the meeting with the supervisee including any agreed actions for next time
- Completion of any documentation that might be required. This would include the supervision agreement, which would highlight elements such as confidentiality, timing, frequency and venues of meeting, rights and responsibilities of both supervisor and supervisee and frequency of reviewing the original contract
- Closing the meeting.

You might compare the above to your own experiences as a supervisee in practice, as well as considering what areas you may need to develop, e.g. making a plan of the meeting beforehand, making a list of reflective questions, familiarising yourself with the documentation, etc. You may also wish to discuss this with an experienced clinical supervisor in practice.

Activity 4

Some of the characteristics of an effective clinical supervisor are:

- An ability to provide a supportive relationship
- Being able to separate your work role from that of being a clinical supervisor
- Ability to engage empathetically
- Being approachable
- Being non judgemental
- Being viewed by others as a credible practitioner
- Being a good listener, incorporating active listening and questioning
- The ability to facilitate reflection in others through the use of guided questioning and a willingness to commit to reflection and feedback yourself
- Being able to help the supervisee in summarising a clinical supervision meeting
- Being able to challenge as well as support the supervisee (and feeling comfortable about challenging)

- Being able to offer effective feedback
- Self challenging skills
- Others?

You might self rate these characteristics on a scale of 1 - 5 and then ask your colleagues to rate you and compare the differences and similarities in your answers. This might assist you in highlighting priority areas to develop.

As you will have noted from the CD-ROM presentation, it is the supervisor's responsibility to create a suitable environment for clinical supervision. This will mean being early for the session to prepare the room. Whilst the emphasis appeared to be on the layout and physical factors relating to the appearance of the room, there will also be psychological issues to consider, such as:

- Is it the same room a manager normally uses to recruit and discipline?
- How interruption free will the room be?
- How could you limit interruptions?
- How will you welcome the supervisee, for example, will the supervisee be expected to knock to enter?
- Will refreshments be available?
- How will the seating be arranged?

Activity 5

Some of the differences between clinical and management supervision are likely to be:

Clinical supervision

- informal process
- enabling process
- supports good practice
- supervisor within practice
- supervisee orientated
- record kept by supervisee
- fluid aims / objectives
- qualitative elements
- optional for practitioners
- emphasis on support
- facilitative
- enhance individual practice

Management supervision

- formal process
- monitoring process
- insists on good practice
- manager often remote from practice
- supervisor orientated (manager)
- record kept by manager
- fixed aims and objectives (e.g. appraisal)
- quantitative elements
- obligatory for practitioners
- emphasis on standards
- authoritative
- enhance the organisation

Activity 6

John Heron's (2001) SIX category supervisory styles or interventions are all available to the clinical supervisor in a clinical supervision meeting and can be sub-divided into whether the interactions (that are directly observable) are authoritative or facilitative interventions. Whilst on the surface it might seem that authoritative interventions are more managerial in nature and facilitative interventions more to do with clinical supervision, in reality any of the six categories might be needed and will also depend on the needs and the developmental stage of the supervisee. However, examining each of the categories may reveal a tendency, as a clinical supervisor, towards a preferred way of intervening or communicating with others.

AUTHORITATIVE INTERVENTIONS	FACILITATIVE INTERVENTIONS
<i>Prescriptive: directs behaviour</i> giving advice, making suggestions – 'should-ing'	<i>Cathartic: space for feelings</i> encouraging the expression of emotions
<i>Informative: imparting knowledge</i> offering information	<i>Catalytic: problem solving</i> drawing issues out and getting below the surface dialogue
<i>Confronting: directly challenging</i> raising awareness of a limiting attitude or behaviour	<i>Supportive: encouraging</i> affirming the worth of the individual – non-judgemental

Although one can get a general intuitive feel for the supervisory style being used (especially as a supervisee), the purpose is to be able to directly observe these styles in practice. It will be helpful to read up on the defining characteristics of each of the interventions in more detail, so that if you are using audio-visual aids (with permission) for one of your meetings you are able to recognise each of the supervisory styles and can make short notes in practice.

Activity 7

Examples of some of the shared responsibilities in clinical supervision are:

- Arranging when and where the next meeting will take place
- Preparing for clinical supervision so time is used effectively
- Determining the frequency and duration of clinical supervision
- Maintaining confidentiality for what goes on in a meeting
- Periodically reviewing the effectiveness of clinical supervision
- Knowing the boundaries of clinical supervision in relation to the organisational policy.

In the event of a clinical supervision relationship breaking down, it is likely that:

- a rationale be given for the reasons for this (often in writing), as this is not always due to dissatisfaction, but perhaps due to a change of circumstance, e.g. leaving the post or needs may be more appropriately met by another supervisor
- the clinical supervisor may advise the supervisee to access another clinical supervisor from a different discipline/speciality for particular issues/aspects of practice, whilst still remaining the main clinical supervisor
- where possible, any disagreements between a supervisee and clinical supervisor will remain between the two parties involved and will be resolved informally. The re-negotiation of the supervisory agreement /contract may assist this process
- in the event of either party wishing to terminate the supervisory agreement /contract, it will be acceptable to do so and a record made of this decision and the line manager informed.

As a general point, it can be helpful to agree, as part of the supervisory agreement / contract at the initial meeting, where clinical supervisors can get appropriate guidance from if they feel that inappropriate topics are being brought into the meetings by supervisees. Sources of support for this may include the clinical supervisor's own line manager, another experienced supervisor or the local education provider that supports clinical supervision training.

Activity 8

Ideas for questions to the FIVE stages of a clinical supervision structure are not dissimilar to those used in the stages of reflection. You will also be able to think of your own examples but in the scenarios, examples of questions used were:

1 Social Stage (settling in)

How are you today?

Would you like a drink?

Would you like to come and sit down?

- 2** Review Stage (what was taken from the previous meeting)
How have things been since our last meeting?
What has happened since the last time we met?
What progress do you think you have made since our last meeting?
- 3** Agenda Setting Stage (deciding on the issue to be explored)
What would you like to discuss today?
I can see you have a lot of issues, but what would you like to focus on today?
What seems to be a priority area to work on?
- 4** Reflective Stage (analysing the issue with the supervisee)
So today you are concerned aboutdo you want to tell me about that?
What thoughts have you had about the situation?
Do you think there might have been a reason for....?
- 5** What Next? Stage (focusing on ways of moving forward as actions)
What are you going to do about....?
What are you going to take away today?
How are you going to get some clarity about...?

Activity 9

- a** In the first scenario, the supervisee unconsciously identifies with her patient then later on in the meeting reveals that she had been 'slightly more sympathetic' as her sister had faced a similar situation. The result of giving this patient more time resulted in her colleagues 'sniping' at the supervisee and accusing her of showing 'favouritism' to the patient by spending a long time doing a bed-bath when she could have been attending to other duties in line with her grade. The clinical supervisor helped the supervisee recognise what was happening and at the same time support the supervisee in clarifying her new role. However, further psychological interventions might have helped to assist the supervisee in understanding how unconscious processes can influence care, resulting in becoming over-involved or 'going the extra mile'. The consequence of this was to make her unpopular with colleagues on a busy ward, where the expectation of others was not to be taking on what was perceived as a care assistant role instead of a more organising role.

In the second scenario, the supervisor allows space for the supervisee to vent strong feelings and emotions following a patient falling out of bed and a resultant meeting with the relatives. The 'safe' space in clinical supervision allowed the supervisee to look at his own perceptions and knowledge limitations in dealing with older patients in a less emotive way. In particular, the values and beliefs of the supervisee were challenged in dealing with this type of patient, e.g. bed blocker resulting in an altered perspective and options for handling the difficult meeting with the relatives.

The third scenario focused on issues around managing time in a patient's own home. Despite being an experienced community nurse, perhaps the rapport that had been developed over time, not unlike the first scenario, may have led to the supervisee becoming over-involved or even over-identifying with the patient, resulting in more time being spent with this patient at the expense of others on the days caseload. Whilst the supervisee issue as an agenda item that was discussed was managing time, further psychological interventions might have been challenging the agenda item and examining what it was about this particular patient that made leaving on time difficult, e.g. exploring the feelings of the nurse with this patient.

- b** Some basic psychological skills have previously been identified in activities 4 and 6 and also contained in the Guided Reading in Study Guide 2. Other basic skills that you might wish to develop further are ways of showing genuineness and respect, being non-judgemental, showing empathy, active listening skills, paraphrasing and summarising and using open questions to encourage deeper exploration of the issues brought to clinical supervision. It is also important as a clinical supervisor to be willing to receive feedback and raise concerns of challenging supervisees in their own clinical supervision.
- c** Although many of the approaches in clinical supervision seem to be somewhat similar to a personal therapy, there are differences. For instance, clinical supervision does not have as its prime concern the promotion of healing for the supervisee; instead it is a supportive process to enable the supervisee to carry out effective work. In therapy, the expectations of the patient or client are that they and their personal needs are at the centre of the relationship. You might contrast previous definitions of clinical supervision in which the supervisee requires support but, at the centre of clinical supervision is the emphasis on effective and safe care delivery. Current debates on whether clinical supervision focuses on the personal, or more professional aspects of the supervisee remain contentious and demonstrate the need for establishing boundaries before starting out on clinical supervision, and if these are not monitored they may easily become blurred. You might also wish to consider that, whilst clinical supervision is not a therapy, does this mean that it may not have therapeutic benefits for the supervisee and perhaps those they look after in practice?

Activity 10

A solution focused approach is similar to structuring a clinical supervision meeting outlined in Activity 8 that has a distinct beginning, middle and an end, but the emphasis is on strengths and not deficits. For example, identifying exceptions to the problems of practice and helping the supervisee to recognise when these are being adequately dealt with and building on this foundation. Both structures can be goal focused, with the supervisee determining the outcome of the meeting and with the aim of working in a collaborative way towards future possibilities instead of paralysis by analysis (of problems). Both structures foster a sense of supervisee responsibility for change and action, although with a solution orientation it is important to follow through with actions for next time, rather than getting straight into the next problem of practice to solve.

Activity 11

The stages of the relationship allow you to see what can be possible within clinical supervision, although the aim is towards working in a collaborative way. This might be more challenging in situations, e.g. due to a shortage of staff when a clinical supervisor is allocated to a supervisee rather than a choice being able to be made. This will undoubtedly initially affect the quality of the clinical supervision relationship, although over time this can be resolved.

It is likely that, as a new supervisor, either consciously or unconsciously, you might wish to impress your supervisee with your knowledge, problem solving or general experience. This can leave the supervisee feeling dependent when, in fact, it is the supervisee who in one sense should guide the supervisor with their issue and what they wish to achieve in a meeting.

Having knowledge of the different stages of a clinical supervision relationship suggests that it is normal to have, or even to expect, challenges and confrontations to progress through to the next stage. Collaboration needs to be distinguished from a cosy collusiveness in which there is little challenge or difference of ideas.

Activity 12

All of the nine standard statements will present challenges in practice. However, organisational support, time, recording and competency may be easily identified as a new clinical supervisor. An inability to find the time in amongst busy practice is one of the ways that clinical supervision can often fall by the wayside, even with what appears to be a sound commitment by both parties at the beginning of the clinical supervision relationship when contracting. Regular absences will be of concern and need to be challenged in the absence of a good reason, as this might signify general difficulties in the relationship.

Until clinical supervision becomes an ordinary rather than an extraordinary event in practice, engaging in the process is likely to make you stand out in the crowd and perhaps even unpopular with colleagues or your manager. Documentation, whilst useful as an aide memoire for preparing for meetings and reflecting on actions after a meeting, remains a contentious issue relating to concerns about confidentiality.

The development of a provisional standard in clinical supervision and the nine statements do at least provide a focus for further discussion on how to meet the inevitable challenges of clinical supervision in practice.



Answers to Progress Checks

Progress Check 1

- 1 Having an organisational policy or guidelines in clinical supervision is helpful in being a reference point in gaining a shared understanding of the corporate values underpinning clinical supervision. It is likely that the roles and responsibilities in clinical supervision will be identified, along with a definition for practice and related documentation.
- 2 Peer supervision is less hierarchical than some other methods of clinical supervision and a method of choice with more senior practitioners or where little if no supervision exists. One of the disadvantages of peer supervision is that the knowledge for practice might be more limited than working with clinical supervisors with a broader experience.
- 3 Based on other discipline-specific supervision models, the way to become an effective clinical supervisor is by having a direct experience of being a supervisee. In addition to the learning from practice by talking about practice, there is the experiential learning of knowing what it is like to receive clinical supervision and exposure to a role model in preparation for making the transition to being a clinical supervisor. A central theme of Study Guide 2 has been the need for all supervisors to also be supervised in that they can obtain feedback on their clinical practice as well as supervision practice.
- 4 The main issue with documentation is the question of confidentiality and the legal status of maintaining supervision records. In most cases, after agreeing to confidentiality during the contractual meeting, the expectation is that the supervisee is responsible for maintaining their own records of clinical supervision, although it is very reasonable for the supervisor to make brief notes on the date, time, venue and some action points to follow up on each meeting.

Progress Check 2

- 1 Clinical supervision differs from therapy, although one might concede that looking at the skills used in disciplines such as counselling and psychotherapy can offer a different perspective on clinical practice. Counselling or psychotherapy intentions are to heal the client and, as such, that client has expectations of the therapist. Clinical supervision is a form of guidance and support through the medium of reflecting on practice, usually with another experienced professional. In clinical supervision personal needs are not the centre of attention; the practice needs of the supervisee are the centre of attention in a professional work context.

- 2** Having a working knowledge of different models and approaches in clinical supervision, including psychological approaches, can broaden the perspective of the supervisee in practice. It is likely that, in gaining knowledge on a range of theoretical perspectives, the clinical supervisor can more intentionally act as a clinical supervisor and be more flexible in meeting the needs of a diverse range of practitioners in a diverse range of practice.

For Your Notes

