



Helen & Douglas House
HOSPICE CARE FOR CHILDREN AND YOUNG ADULTS

Clinical Supervision Toolkit

Meet the Team



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The Helen & Douglas House Clinical Supervision Toolkit review and development of the ***Introduction to Clinical Supervision e-learning module*** has taken place between January and April 2014. We hope you find this toolkit a useful resource to support you learning about and participation in clinical supervision.

We would like to thank all those who have generously given their time and shared their expertise to support and inform this review of the Clinical Supervision Toolkit. The clinical supervision project team, the toolkit review and e-learning module have been funded by a grant from Health Education Thames Valley. It has been designed by Chris Woodrow.

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Clinical Supervision Toolkit

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A Note About Terms

The literature tends to refer to people who are participating in supervision as ‘supervisees’ and to those who are facilitating supervision as ‘supervisors’. The possibility for confusion arising around the similarities in these terms and the simple difficulty of saying them both regularly, often in the same sentence, led those with a responsibility for clinical supervision at Helen & Douglas House to adopt new terms. Hence those participating in supervision are referred to as **‘participants’** and those delivering supervision are referred to as **‘facilitators’**.

Background

Helen & Douglas House is an independent hospice charity based in Oxford, providing supportive and specialist palliative care to children and young adults.

There are two hospice houses: Helen House for children from birth to 18 years, and Douglas House for young adults up to the age of 35. Each offers specialist symptom and pain management, medically-supported short breaks and end-of-life care, as well as counselling and practical support for the whole family.

The publication of the first edition of this toolkit in 2011 marked an acknowledgement of the long history of reflection on practice and clinical supervision at Helen & Douglas House. Clinical supervision is widely acknowledged as a way of promoting safe accountable practice. For us, developing the toolkit was the beginning of a journey to refresh and renew our organisational commitment to and vision for clinical supervision.

As our experience has continued to grow and our vision has begun to be realised, we have embraced clinical supervision in its widest sense, to support all staff and volunteers whose role brings them into direct contact with patients and families. In recognition of that this second version is aimed broadly at those working within the helping professions.

Although we hope this toolkit may also be helpful for those working in other disciplines, we acknowledge that much of the literature and indeed the experience that we have drawn upon to develop this toolkit are rooted in nursing and healthcare.

Introduction

For all of us who work in the helping professions, caring for others is at the heart of working life.

For us to be able to provide compassionate, person-centred care in an increasingly complex world, we need to care for ourselves. We need to engage in a parallel process that gives us experience of person-centred support and development: clinical supervision.

In this second version of the *Helen & Douglas House Clinical Supervision Toolkit*, we have retained what our experiences have taught us is useful and relevant, while adapting, adding and updating where necessary. What hasn't changed is our organisational commitment to clinical supervision. We want to share our learning and our experiences in the hope that we will inspire you to reflect, grow and imagine the possibilities for clinical supervision where you are.

Part 1 of the toolkit is for everybody working in the helping professions and beyond. We aim to provide an overview of the role of clinical supervision as a mechanism for supporting well-being and good practice. We explore definitions, benefits and tools to support the provision of clinical supervision.

Part 2 is made up of three chapters that provide tailored information for **participants, facilitators, and managers & organisations.**

For participants the toolkit:

- Introduces the concept of clinical supervision and reflection.
- Explores why we need clinical supervision and how it supports us in our work.
- Offers suggestions about preparing for and participating in clinical supervision.

For actual and potential facilitators the toolkit:

- Introduces the role of the facilitator.
- Explores the skills needed for effective facilitation and considers how these can be developed.
- Offers suggestions about self-care.

For managers & organisations the toolkit:

- Introduces the role of managerial and organisational support in clinical supervision delivery, policy development and service evaluation.
- Explores resource implications of clinical supervision delivery.
- Offers suggestions about implementing and developing clinical supervision provision.

The Toolkit

This toolkit has been developed as a resource, both for those already involved in clinical supervision and those developing an interest.

In each section of this toolkit you will find **activities**  to help you focus on your own thoughts and experiences regarding the various aspects of clinical supervision. They are provided with the aim of supporting your learning and skills development to be relevant to you in your individual situation.

By working through this toolkit you will have the opportunity to develop the skills and awareness to engage effectively with clinical supervision.

Taking a proactive approach to developing and participating in clinical supervision in your organisation will enable you to derive optimum benefits from it.

Part 1

What is Clinical Supervision?

Towards a definition

There have been many attempts to define clinical supervision:

The Care Quality Commission states that *“The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect on and discuss their work and their personal and professional response to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice.”*¹

The Royal College of Nursing states *“[Clinical supervision is] the term used to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex clinical situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self-assessment and analytic and reflective skills.”*²

Hawkins and Shohet suggest *“Supervision can be an important part of taking care of oneself, staying open to new learning, and an indispensable part of the individual’s ongoing self-development, self-awareness and commitment to learning.”*³

Bishop and Sweeney described it as *“A designated interaction between two or more practitioners within a safe and supportive environment, that enables a continuum of reflective critical analysis of care, to ensure quality patient services and the well-being of the practitioner.”*⁴

In essence all definitions of clinical supervision describe five key aspects:

- 1** A reflective component.
- 2** Support from a skilled facilitator.
- 3** Focus on clinical practice (including team dynamics, communication and personal coping).
- 4** Professional development.
- 5** Improving patient treatment and care.

Helen & Douglas House Experience

In practice we have found it helpful to consider a definition which reflects what happens in clinical supervision.

As part of the clinical supervision training offered to facilitators at Helen & Douglas House, course participants are encouraged to come up with their own definitions:

“Clinical supervision provides a support network with lots of different options, one of these is for a group of us to get together to talk about difficulties, to talk about things which have gone well, to gain support and learn together.”

“Clinical supervision is about engendering an organisational culture which provides a safe environment to support every staff member and promote excellence in practice”

“The aim of clinical supervision is to provide a flexible framework of support for all staff and volunteers so that standards of care can be improved and maintained”

“Clinical supervision is an opportunity, supported by the organisation, for its workforce to explore their personal and professional feelings evoked by their work. It takes place in a formal, structured and contained environment with a clear establishment and understanding of its boundaries.”



Activity

Take some time to think about what clinical supervision means to you, in your own work life and within your team or organisation.

From these thoughts and ideas, try to come up with your own personal definition of clinical supervision.

What's in a name?

The term clinical supervision is in itself problematic. It is well documented that, for some, the term raises concerns about being watched, controlled and monitored, which can in turn lead to resistance to taking part.⁵

If the concept were being developed today it is likely that a different name which more clearly highlights the supportive intention of the process would be chosen.

Some analogies from prominent authors in the field of clinical supervision may offer a different perspective:

- 1 **“Super-vision”** – developing a super form of vision through which we can take a fresh and deeper look at our experiences in our work.³
- 2 **“Making sense of the swampy lowlands of clinical practice”** – examining the subtle and unseen aspects of our experiences of working life.⁶
- 3 **“Putting practice under the microscope”** – taking an in-depth look at a specific aspect of our experience that has touched us in some way.⁷

As we have broadly considered what clinical supervision is, it may be helpful to compare this to what clinical supervision should not be.



Activity

Take some time to consider what clinical supervision is, how we can use the space and what happens in the space.

Having done that, think about what clinical supervision is not, the things we should not use that space for and things which should not happen in that space.

- List your thoughts either in your head or on paper and compare the different ideas.
- How does this compare with your experience of clinical supervision?

What clinical supervision is and what it is not

This table is compiled from literature sources and also from participant's responses in Helen & Douglas House clinical supervision training.

Clinical supervision is:	Clinical supervision is not:
<ul style="list-style-type: none">• An exploration of the relationship between actions and feelings.• A tool for professional development.• A safe place.• A place of learning.• Supportive.• A place to share burdens of work.• A structured framework for reflection.• Mutually supportive for all.• Open to questions and challenges.• About listening and being heard.• Inclusive.• Affirming.• Self-driven/self-owned by participants.• Supportive of personal accountability.	<ul style="list-style-type: none">• A means of checking up on practice.• A judgement on you or your practice.• An assessment.• A performance management tool.• Therapy (although it may be therapeutic).• Counselling or an opportunity to practice as a counsellor.• Controlled and delivered by managers.• Part of the reporting process.• A teaching session.• Mentoring by the facilitator.• Appraisal.• A “personal soap box”.• A place for snooping.• A place for blame.• A place to run down other members of the team.• A place for the facilitators' agenda.• A dumping ground, or place for gossiping or moaning.

Historical perspective

Clinical supervision has a long history in the helping professions, particularly in counselling and social work. Due to the variety of roles undertaken in medicine, nursing and allied healthcare professions, clinical supervision has adapted over the years to meet the broader needs of practitioners.

From a nursing perspective, clinical supervision was first described in terms of being a systematic tool for improving practice in the 1993 Department of Health strategic document *A Vision for the Future*.⁸

Clinical supervision was introduced widely into the nursing profession to encourage the use of reflective practice, sharing of information and supporting staff in their development.²

Reflection

The concept of reflection is an integral part of clinical supervision. In order to fully participate in clinical supervision it is necessary to understand what reflection is, and how to practice it.

Reflection, simply described, is an *“activity in which people recapture their experience, think about it, mull it over and evaluate it”*.⁹

Reflection is not a purely intellectual activity: it is a dynamic process that requires us to pay attention to the feelings evoked by an event and invites ideas about how things could be done differently.

Reflection requires *“a combination of thinking, emotion and commitment to action”*.¹⁰



Activity

Reflecting on practice is likely to be something that you do without realising.

As you consider these definitions of reflection, draw to mind an experience from your own practice that, at the time, felt difficult, challenging or uncertain. Try to recall your reflections from that time. Notice the aspects you reflected on, and notice any changes in your perspective now.

Reflection is a powerful tool to enable learning from our experiences. Facilitated reflection is particularly effective because it:

- Acts as a catalyst to think differently.
- Enhances motivation that may falter during every day experiences.
- Assists a move from anxiety into positive energy for action.
- Addresses the gap between actual and desirable practice.
- Promotes deeper and critical levels of reflection.
- Challenges participants to respond differently in the practice situation.
- Supports clinicians to act on their insights with integrity.
- Supports staff morale during difficult times.
- Enables supervisees to be heard and re-energised.

Information and activities to help you develop your reflective skills are provided in ***Tools for Clinical Supervision*** (page 31) and ***Information for Participants*** (page 43) sections.

How might clinical supervision be delivered?

In the simplest terms clinical supervision is guided reflection.

It can be delivered in many different formats. The three main modes of delivery, as well as some possible benefits and challenges associated with them, are highlighted here:

	Description	Possible benefits
Individual	<ul style="list-style-type: none"> • May be provided regularly for individuals with a single named facilitator over an extended period of time. • Can be ad hoc, as requested to deal with specific incident or issue. • May include brief interventions. 	<ul style="list-style-type: none"> • Development of trusting relationships between facilitator and participant maximising opportunity for challenge and growth. • Ad hoc sessions useful for providing more immediate support and opportunities for learning from difficult situations that arise.
Peer	<ul style="list-style-type: none"> • Usually involves two or more participants facilitating their own sessions. These participants are usually experienced in clinical supervision or have previously acted as facilitators. • Can also involve participants rotating into the role of observer who gives feedback at the end of the session (also known as triadic supervision). 	<ul style="list-style-type: none"> • May be easier for some people to engage with – comfort in using skills and resources of trusted colleagues to support reflection on actions/events. • Can be helpful as usually those involved will be familiar with the situation being discussed.
Group	<ul style="list-style-type: none"> • Can be provided in fixed groups of peers or colleagues operating at similar level with regular named facilitator. • Or in fluid drop-in groups with a pool of alternating facilitators. 	<ul style="list-style-type: none"> • Safety and trust can be built up over time in fixed groups. • Great potential to share knowledge and experience and learn from each other. • Cost effective way of providing access to regular clinical supervision.

Possible challenges

- Expensive to deliver to large numbers of people on regular basis.
- Facilitator and participant need to be appropriately matched.
- Need enough identified and trained facilitators in an organisation to be able to provide an ad hoc service reliably.

- Sessions may become too informal, lacking the process and challenge to enable growth.

- Facilitators need to be skilled at managing group dynamics as well as the reflective process.
- Drop-in groups can feel too unsettled for some participants.
- Ground rules and process need to be agreed at each drop-in session which can be time consuming.

Individual organisations and managers will need to decide on the most appropriate way of delivering clinical supervision in their situation for their employees. It may be that a range of options are required.

It may be helpful to offer participants a choice of how they can engage in clinical supervision. It is likely that participants will have their own preferences, based on a number of factors including their personality and any past experience of taking part in clinical supervision.

The responsibility for providing supervision rests with the designated managers within an organisation.

The responsibility for getting the most out of clinical supervision rests with the individuals taking part.

Helen & Douglas House Experience

The Helen & Douglas House menu of clinical supervision and support opportunities

At Helen & Douglas House the clinical supervision needs of the majority of staff and volunteers are largely met through drop-in group supervision. These group sessions have no fixed membership and are convened weekly by a rolling bank of trained facilitators.

However it is recognised that this drop-in group supervision may need to be supplemented by clinical supervision in a different format.

When facilitators are trained, they are given the opportunity to develop the skills to provide a range of supportive interventions, which enables them to deliver much of what is on offer on the clinical supervision menu.

Some specialist support, as well as clinical supervision for our senior management team, is provided by outside facilitators. Clinical incident analyses and debriefs after a death or a critical incident are usually led by one of the medical team, a senior member of the family support team, or the clinical supervision lead.

Participants at Helen & Douglas House can choose from the following menu:

- Drop-in groups – facilitated sessions are available on a weekly basis, there is no fixed membership.
- Peer supervision.
- Individual supervision.
- Debrief after a death or a critical incident.
- Critical incident analysis.
- Brief interventions – where a participant identifies a facilitator on an ad hoc basis, usually at point of challenge to get focused support with dealing with a particular issue.
- External clinical supervision – the services of an external facilitator are used to support staff in senior clinical management roles.
- Personal reflection.
- Sessions to support volunteers whose role brings them into direct contact with patients and families.
- Ad hoc sessions on a needs-led basis to support staff in non-clinical roles who have direct contact with patients and families (e.g. fundraisers).

Our clinical supervision policy states that staff must participate in a minimum of six episodes of clinical supervision per year. The format can be chosen by the participant, but cannot rely solely on written reflection or peer supervision. Evidence of participation in clinical supervision is documented by the participant (see **Resources** section, page 99) and must be provided at appraisal.

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Why do we need Clinical Supervision?

Why do we need Clinical Supervision?

Most practitioners will recognise the weighty feeling that can be experienced when providing care for those in pain or distress, of working in conditions where interpersonal dynamics are difficult, or when we are required to perform at the limits of our comfort or capabilities.

Working in the helping professions, we may feel that carrying these burdens is par for the course. The culture of helping suggests that we need to carry these burdens discreetly and to present a professional front.

Clinical supervision is a space where we can explore the effects of our work, and make sense of the feelings our work evokes. It provides the opportunity to replenish reserves and bolster our resilience by considering new strategies. It enables us to consolidate learning and celebrate our achievements.

Helen & Douglas House Experience

At Helen & Douglas House we recognise that our desire is always to do the best that we can for those that we care for. If we are to be enabled to provide compassionate, non-judgemental care for our patients, we need to explore and learn from all that happens while providing that care.

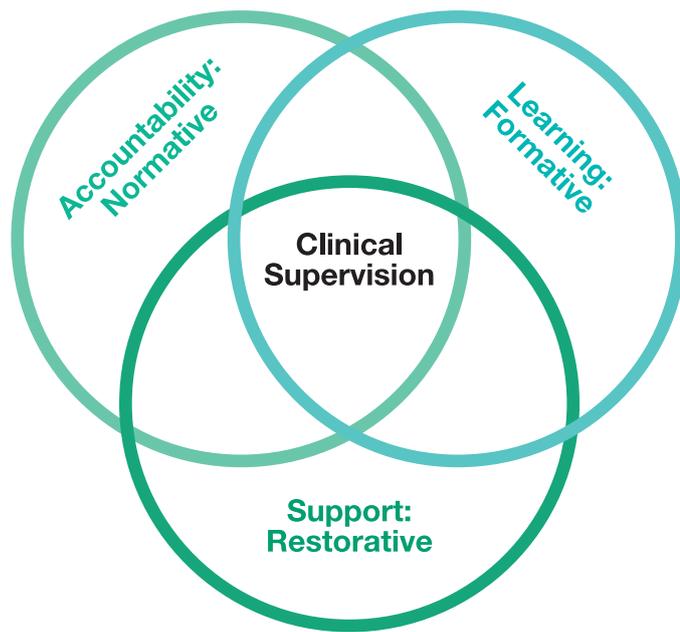
Our commitment to clinical supervision at Helen & Douglas House is a recognition of the fact that without structured support mechanisms to help us hold the stresses associated with our work, it can become unsustainable.

Functions of clinical supervision

The benefits derived from clinical supervision can be related to the functions of clinical supervision identified by Proctor.¹

This interactive model of clinical supervision describes three key components of effective clinical supervision: **accountability**, **learning** and **support**.

Accountability	<p>Accountability is also referred to as the normative component. It focuses on supporting individuals to develop their ability and effectiveness in their clinical role, enhancing their performance for and within the organisation. The aim is to support reflection on practice with an awareness of local policy and codes of conduct.</p> <ul style="list-style-type: none">• Supports delivery of a high standard of ethical, safe and effective care.• Enhances performance.
Learning	<p>Learning is also referred to as the educative component. It enables participants to learn and continually develop their professional skills, fostering insightfulness through guided reflection. It focuses on the development of skills knowledge, attitudes and understanding.</p> <ul style="list-style-type: none">• Supports personal and professional development.• Encourages and supports lifelong learning.• Helps to identify further training and development needs.
Support	<p>Support is also referred to as the restorative component. It is concerned with how participants respond emotionally to the work of caring for others. It fosters resilience through nurturing supportive relationships that offer motivation and encouragement and that can also be drawn upon in times of stress.</p> <ul style="list-style-type: none">• Supports self-care and well-being.• Provides insight into our emotional responses.• Enhances morale and working relationships.



Activity

Reflect on your own experiences of clinical supervision to date.

Consider how these three functions have been present, or not, in your clinical supervision.

You may find it helpful to consider:

- Whether any of the functions dominated the session.
- Whether any of the functions were absent.
- Which interventions/questions/reflections supported each of the functions.
- Whether you feel more comfortable or less comfortable with any functions in relation to the others, and why this might be the case for you.

Benefits of clinical supervision for participants

In a busy working life it can be very difficult to find the time and energy required to engage in clinical supervision.

In a culture where we put the needs of others before our own it takes courage to acknowledge our own needs. Participating in clinical supervision is a measure of the value we place on ourselves as individuals.

The Nursing and Midwifery Council identified the possible benefits of receiving effective clinical supervision as:

“Improved capacity to identify solutions to problems, increased understanding of professional issues, improved standards of patient care, opportunities to further develop skills and knowledge and enhanced understanding of own practice.”²

The Care Quality Commission guidance suggests:

“It can help staff to manage the personal and professional demands created by the nature of their work. This is particularly important for those who work with people who have complex and challenging needs – clinical supervision provides an environment in which they can explore their own personal and emotional reactions to their work. It can allow the member of staff to reflect on and challenge their own practice in a safe and confidential environment. They can also receive feedback on their skills that is separate from managerial considerations.”³

It has been argued that effective clinical supervision and the possibility for learning, development and support it provides can be protective against work related stresses.⁴

Helen & Douglas House Experience

A focus group of Helen & Douglas House staff and volunteers were asked to consider the benefits of clinical supervision:

“It shows that the company is giving us some back up and some support.”

Catering team member

“I’ve certainly found quite a few times that you’re able to support your colleague or are perhaps able to talk to them about your own coping strategies, mechanisms and things like that. I find that incredibly helpful from that point of view.”

Care team nurse

“It also makes you feel like you’re not on your own because someone else has the same opinion; you know it’s not just you who is feeling like that.”

Care team volunteer

“I think it’s useful for when there’s something that you want to talk about but you’re not quite ready for it to escalate to higher management or whatever, I think it’s quite a good tool to be able to sit down and talk about it and see where everybody else is with it, if you’ve got a group meeting.”

Care team member



Activity

Whether you have participated in clinical supervision in the past, or hope to in the future, it can be helpful to reflect on the reasons why we should invest our time and energy in engaging in clinical supervision.

Take some time to consider how participating in clinical supervision may benefit you personally and professionally. Consider how your participation in clinical supervision may benefit your team and organisation.

Benefits of clinical supervision for teams and organisations

Clinical supervision is a structured process that requires both commitment and investment.

In the current economic climate where resources are stretched it can be difficult to prioritise activities which do not directly and measurably contribute to service delivery.

The benefits of recognising the support needs of staff can be seen both in the effectiveness of individual members of staff and the dynamics of teams. Providing clinical supervision can also communicate the value the organisation places on its staff members.

The possible benefits to organisations of implementing clinical supervision may include:

- Improved practice from confident practitioners.
- A culture in which work is valued and patients are valued.
- Improved recruitment and retention of staff.
- Increased accountability and motivation.
- Enhanced well-being and reduced sickness rates.
- Improved communication among workers.
- Maintenance of clinical skills and quality practice.
- Increased job satisfaction.
- Safeguarding of standards of patient care by promoting best practice.
- Promoting self-awareness and professional accountability.
- Increased staff commitment because they work in a culture where learning and development are valued.
- Opportunities for staff to be proactive in improving care.

The Care Quality Commission advises:

“Clinical supervision should be valued within the context of the culture of the organisation, which is crucial in setting the tone, values and behaviours expected of individuals. It should sit alongside good practices in recruitment, induction and training to ensure that staff have the right skills, attitudes and support to provide high quality services.”

“Importantly, clinical supervision has been linked to good clinical governance, by helping to support quality improvement, managing risks, and by increasing accountability.”³

In addition to the overall benefits that clinical supervision can offer to participants, facilitators and managers, it is also helpful to consider how the way that clinical supervision is provided influences the benefits derived from it.



Activity

Clinical supervision groups may be uni-professional (colleagues working within the same discipline or professional role) or multi-professional (colleagues working in a range of disciplines or professional roles).

Thinking about the team or organisation that you are part of, what might be the advantages and disadvantages of uni-professional and multi-professional supervision?

References

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Tools for Clinical Supervision

What do we mean by tools?

There are a number of ‘tools’ that can help to translate the concept of clinical supervision into the practicalities of facilitating and participating in it.

These ‘tools’ are what the clinical supervision literature refer to as models. They describe what clinical supervision is, discuss the fundamental elements that are part of it and shape the goals and outcomes of clinical supervision. In essence models are concerned with what clinical supervision is and does, its purpose.

There are also other tools that can be used alongside clinical supervision models; these are referred to as reflective models and frameworks. These reflective models and frameworks describe the processes that support the ‘task’ of clinical supervision. In essence these are concerned with what is done, how and by whom in clinical supervision, the process of clinical supervision.

For clinical supervision to be provided within an organisation, there needs to be agreement about which model of clinical supervision is most appropriate to be implemented in that organisation.

The model adopted will define what clinical supervision is for that organisation and as such will help define how it is to be provided and which reflective models and frameworks will support clinical supervision practice.

Helen & Douglas House Experience

Models and frameworks we have adopted:

At Helen & Douglas House we use *Proctor’s Functions of Clinical Supervision Model* to define the purpose of supervision. The focus on learning, accountability and support is aligned with the philosophy of clinical supervision adopted by the organisation.

As an overarching framework we introduce facilitators to the *Seven Eyed Supervision Model*. This model promotes a holistic approach to clinical supervision. It places the patient at the centre throughout the reflective process. This is aligned with the patient/family centred philosophy of care at Helen & Douglas House.

Facilitators are then encouraged to use develop their own style of facilitation, using reflective models or frameworks to support the process of reflection within the session.

Hawkins and Shohet's Seven Eyed Supervision Model¹

Hawkins and *Shohet's Seven Eyed Supervision Model*: This is one example of a model; it defines what clinical supervision is through the processes that are present within it.

	Activity	Goal
1	Thinking about the content of the participants interaction with the patient.	Increase the quality of attention to the patient by focusing on the interaction with the patient.
2	Exploring strategies and interventions.	Moving beyond being stuck in the moment and beginning to consider alternative strategies, interventions and outcomes.
3	Exploring the relationship between participant and patient (Transference).	Explore the dynamics of the relationship between the participant and patient.
4	Exploring how work with the patient is affecting the participant (Counter-transference).	Increase self awareness and develop the capacity to respond to patients.
5	Exploring what is happening in the here and now in the relationship between facilitator and participant (Parallel Process).	Ensuring the quality of the relationship between the participant and the facilitator is maintained.
6	Facilitators relationship with the participant.	Use the facilitators thoughts, images and feelings in the here and now of the session to help the participant to reflect more deeply.
7	The wider context.	Bring an awareness of organisational structures and frameworks, professional codes of conduct and ethical codes.

This model identifies four elements involved in clinical supervision, and considers each of these in relation to others: facilitator, participant, patient (or patient’s relative or a colleague) and work context.

Process	Example
Participant is helped to re-live the incident/experience and recall it in detail.	Thinking about the how the patient presented, what they chose to share and considering what the patients perspective might have been.
Participant is helped to consider the experience, think about the alternatives and the possible alternative outcomes.	Thinking about what was done, how, why, when and by whom. Thinking about alternatives and visualising potential outcomes.
The participant is helped to stand outside of their relationship with the patient and see it afresh.	Thinking about what the participant first noticed about the nature of their contact with the patient, whether this patient or the scenario brings forward any issues from the past and recognising the roles of both parties in the relationship.
The participant is helped to explore how their work is affecting them, both consciously and sub-consciously, and to think about how this might be affecting their responses.	Through focusing on the participant, think about how the participant reacts to the patient, the feelings evoked for the participant, and what thoughts and feelings the participant has absorbed from the patient.
The participant is helped to consider and understand the emotional impact of the supervisory process as a parallel process to understanding the impact of their work with patients.	Thinking about moods and opinions of the participant in the session, reflecting on the mood and opinions of the patient in the scenario presented by the participant.
Facilitator attending to their own internal dialogue, recognising anything within themselves that they need to attend to in order to maintain their own role and develop their facilitation skills.	This might include the facilitator offering the thoughts and feelings that are emerging as they listen to the participant.
The participant is helped to see their work in the wider context, considering how the quality of their work is influenced by the context, how ‘off stage’ characters influence their experiences and interactions and the impact of social, cultural, political and economical factors.	This may involve thinking beyond the scenario, reflecting on contextual interpretations or assumptions and considering the impact of the wider context on the experiences of the participant and the patient.

Reflective models and frameworks

Our experience suggests that there is no ‘one size fits all’ model. There are many reflective models and frameworks available.

Using a reflective model or framework can help us to keep a clear process in mind: helping facilitators to support structured reflection, to keep the participant(s) focused and to increase the effectiveness of the reflective process.

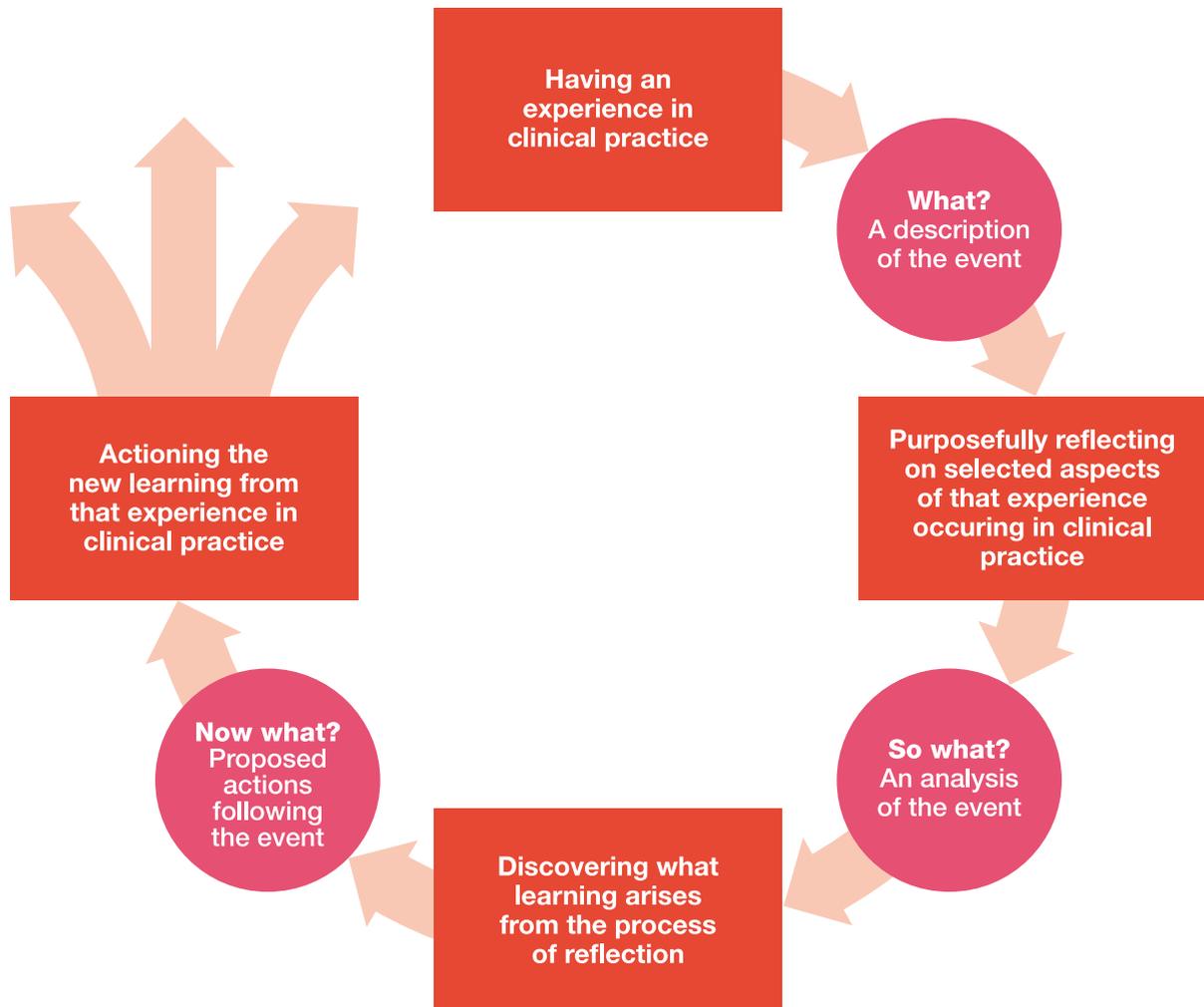
When choosing a reflective model or framework it is important to consider:

- The needs of the participant(s).
- The scenario/experience.
- The level of skill, confidence and experience of the facilitator.
- The level of skill, confidence and experience of the participant(s) in reflection.

Reflective models and frameworks draw on experiential learning theory. Their common objective is to clearly identify learning and actions to take forward.

Driscoll's Model of Reflection²

This is one example of a reflective model based around the questions:
What? So what? Now what?



It can be helpful to think about those headings as the beginning of the questions that a facilitator might pose:

What?	Descriptive level	<ul style="list-style-type: none"> • What are the key events of this experience? • What are the key aspects of this experience? • What were you trying to achieve? • What were your reactions to it – then and now? • What were the responses of others – then and now? • What is your purpose for revisiting this experience?
So what?	Theory and knowledge building level	<ul style="list-style-type: none"> • So what does this mean? • So what informed your actions/behaviour? • So what other knowledge and experience can you bring to the situation? • So what could you do differently? • So what is your new understanding of the situation now?
Now what?	Action planning level	<ul style="list-style-type: none"> • Now what are the implications for future experiences? • Now what are the broader issues I need to reflect on/consider? • Now what is my action plan going forwards?

Helen & Douglas House Experience

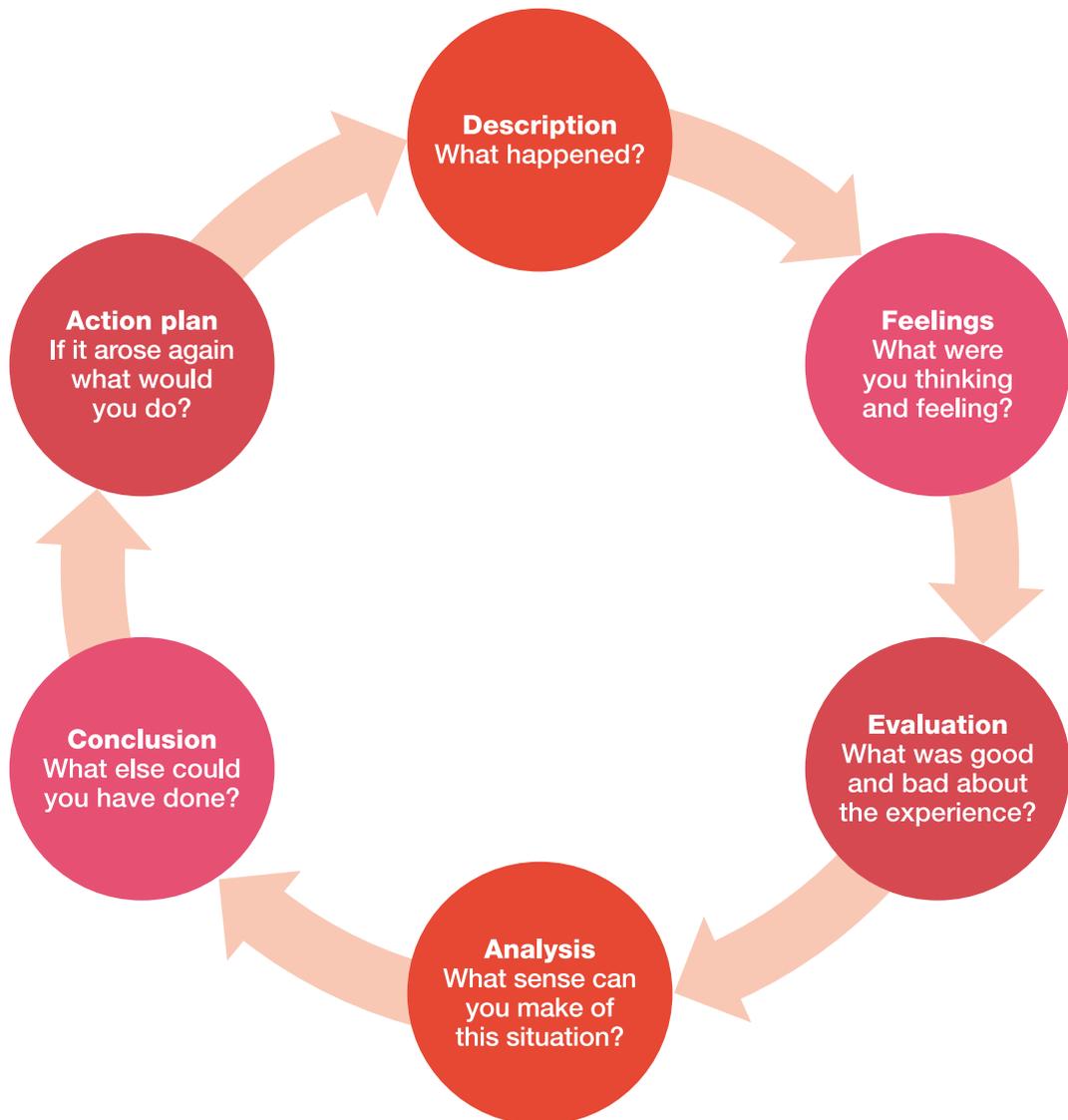
At Helen & Douglas House we find that this model supports the drop-in group style of supervision well.

This model offers opportunities to reflect on experiences yet is simple to navigate and apply and can be used by those facilitators and participants with limited experience of reflective models.

As the drop-in groups do not have a fixed membership, it is helpful to visually see that learning is owned by the participants, and that in this way this discrete episode of clinical supervision is finished. Models that visually ‘close the cycle’ can cause some participants and facilitators to feel that the work of supervision is unfinished if they cannot come back together as a group and revisit the learning.

Gibbs Reflective Cycle³

This is another example of a cyclical model of reflection. This can be used as a structure for guided reflection, for groups or individuals. Critics of this model suggest that it lacks depth; however the skill of the facilitator is in asking questions that help the participant to reflect at a deeper level.



At Helen & Douglas House we recommend this as a tool to support personal and written reflection.

Johns' Model for Structured Reflection⁴

Johns' Model for Structured Reflection is intended as a guide to help navigate reflection. It can be used by individuals for personal reflection, and within clinical supervision for individuals and for groups.

- Bring the mind home
- Focus on a description that seems significant in some way
- What particular issues seem significant to pay attention to?
- How were others feeling? What made them feel that way?
- How was I feeling? What made me feel that way?
- What was I trying to achieve and did I respond effectively?
- What were the consequences of my actions on the patient, others, and me?
- What factors influenced the way I was feeling, thinking, and responding?
- What knowledge did or might have informed me?
- To what extent did I act for the best and in tune with my values?
- How does this situation connect with previous experience?
- How might I respond more effectively given this situation again?
- What would be the consequences of alternative actions for the patient, others, and me?
- What factors might constrain me acting in new ways?
- How do I *NOW* feel about this experience?
- Am I better able to support myself and others better as a consequence?
- Am I more able to realise desirable practice?

In a busy working environment, the beginning of *Johns' Model for Structured Reflection* invites us to 'bring the mind home'. This describes the process of stepping away from the busyness, burden and pressures of our work to really bring ourselves into clinical supervision, so that we are present in the space, not only physically, but also psychologically and emotionally.

Helen & Douglas House Experience

At Helen & Douglas House we offer *Johns' Model for Structured Reflection* as one which can help us find the words to facilitate clinical supervision. We recommend that facilitators adapt the questions and phrases to their own style and way of speaking.

In following the same patterns and themes of questioning, the process of clinical supervision can feel familiar even when the facilitator and/or our co-participants are different at each episode of supervision. This sense of a 'common language' can serve as a shorthand to draw us quickly and fully into reflecting together.



Activity

Take some time to think about these models in the context of a specific experience and/or your specific work context.

Think of an experience or issue you have recently encountered. Take some time to reflect on it, using one of the reflective models described here or another one that you are familiar with. You may find it helpful to make some notes if you do this individually, or you may wish to work with a colleague and share your reflections together.

Take some time to consider:

- Why you chose the model you did?
- How your choice of model may change at different times, for different experiences, for different settings – and why this might be so.
- How might your reflection and outcomes be different when you use different models?

References

- ¹ Hawkins, P and Shohet, R (2012) *Supervision in the Helping Professions* (4th Edition) Maidenhead: Open University Press
- ² Driscoll, J. (2007) *Practising Clinical Supervision* (2nd Edition). Edinburgh: Balliere-Tindall
- ³ Gibbs, G. (1998) *Learning by Doing: A Guide to Teaching and Learning Methods*. Oxford: Further Education Unit, Oxford Polytechnic
- ⁴ Johns, C. (2013) *Becoming a Reflective Practitioner* (4th Edition). Oxford: Wiley-Blackwell

Part 2

Clinical Supervision: Information for Participants

Clinical Supervision: Information for Participants

Participating in clinical supervision involves effort and commitment.

This chapter looks at ways that you can approach clinical supervision as a participant to help ensure that you are able to reap the full benefits of the supervision that is on offer to you.

Roles and responsibilities

Clinical Supervision is a supportive activity which is owned and driven by you, the participant.

To get the best out of clinical supervision as a participant you need to take some responsibility for ensuring the clinical supervision you take part in meets your needs.

The Care Quality Commission suggests participants should:

- Prepare for supervision sessions, which includes identifying issues from their practice for discussion with their supervisor.
- Take responsibility for making effective use of time, and for the outcomes and actions taken as result of the supervision.
- Take an active role in their own personal and professional development, keeping written records of their supervision.¹

Helen & Douglas House Experience

At Helen & Douglas House participants are encouraged to be proactive in ensuring their needs for supervision are met.

There is a menu of different kinds of supervision on offer which means that individual staff can participate in clinical supervision that best suits their needs.

✓ TIPS FOR PRACTICE

Whilst a full menu of clinical supervision and supportive interventions (see page 18) may not be available to you, an awareness of what kind of supervision you have found useful and where your own particular challenges lie will help you negotiate a style of supervision that is helpful to you.

Bear in mind that opting for what is comfortable may not always be where the best learning lies.

Barriers to engaging in clinical supervision

Perhaps as you have read the toolkit you have begun to appreciate the potential value of participating in clinical supervision.

Perhaps, for you, clinical supervision is something that you have experience of, and know for yourself how it supports and develops your practice.

For many people, this will not be the case. For a number of reasons people can feel, at best ambivalent about clinical supervision, and at worst, resistant to it.

You may feel that there are many things that come between you and participating in clinical supervision. Some of these things will have practical components like pressures on your time, staffing levels, the provision and availability of well facilitated clinical supervision.

Some of the things that get between you and participating in clinical supervision will be your own personal barriers. In order to fully participate in and get true benefit from clinical supervision, you will need to be committed to recognising and challenging your own barriers to it.

Some of the barriers you might recognise:

- Clinical supervision is mandatory, I just go to 'tick the box'.
- It's not relevant to me, I don't have any issues.
- I like things the way they are.
- I don't want to dwell on the things that have gone wrong.
- I don't want to hear about everyone else's problems.
- I'm a professional, feelings don't come into it.

Whatever your own personal barriers may be, it can be helpful to ask yourself the following question;

“Why do I feel the need to protect myself from clinical supervision?”

The barriers or defence strategies that you construct get in the way of your benefiting from clinical supervision and may, in themselves, cause other difficulties for you. It can be quite a journey from a place of concern about clinical supervision, to an acceptance of the benefits of it and a commitment to participate in it.²



Activity

A useful early exercise in reflection may be to take some time to consider how any past experiences of clinical supervision and your own beliefs about its benefits or worth affect the way you feel about taking part in supervision today.

Developing an understanding of how past experience of clinical supervision, whether good or bad; can affect your current willingness to take part may well help you to get the best out of what is on offer.

Contracting

Depending on the policy in place in your organisation and whether you are involved in individual or group supervision you may be asked to enter into a clinical supervision contract.

Contracting for individual clinical supervision

In an individual clinical supervision situation the contract represents a working agreement between the participant and the facilitator and in addition reflects the expectations of the organisations and professions involved.³

At minimum it should outline:

- The purpose of the clinical supervision.
- The regularity, duration and location of each session.
- Under what circumstance it is acceptable to cancel a clinical supervision session.
- How records will be kept and by whom.
- How confidentiality will be maintained and the circumstances under which confidentiality will be broken.
- How the clinical supervision will be reviewed and evaluated.
- How the supervisory relationship could be ended.⁴

Contracting in individual clinical supervision may also address the style and process of the clinical supervision.

Contracting for group clinical supervision

In group supervision contracting can be more akin to establishing ground rules. Contracts should at minimum address all of the above, but are likely to also include aspects that relate to whether the group is open to new members and how the process will be managed, respectful communication within the group, how topics for discussion are chosen and how time is allocated.

In drop-in group situations these ground rules need to be established at each session.

Proctor suggests that:

“Contracts and working agreements cannot ensure trusting participation. However declaring or negotiating them is an opportunity for clarifying and amending intentions and expectations.”⁵

Examples of contracts for individual and group supervision can be found in the **Resources** section (page 99).

Confidentiality

Clinical supervision can feel challenging because it requires us to share of ourselves which can lead to feelings of vulnerability.

To get the best out of clinical supervision it is important to be able trust that the feelings or experiences you bring will be treated with respect and importantly confidentially.

Confidentiality requires that what is said in the clinical supervision space stays in the room unless:

- A** All those involved in the session agree that a specific issue or learning points may be shared – clarity will be needed with regards to what and with whom.
- B** Disclosure relates to harm or risk of harm to a patient or individual.
- C** Contravention of law, professional code of conduct or local policy comes to light.

In cases **B** and **C** the facilitator will need to make it clear to the participant(s) who will need to be informed and how.

Record keeping

Keeping records from clinical supervision sessions can help you to:

- Revisit your discussions, reflections and action points over time.
- Provide evidence that you have participated in clinical supervision.
- Document any agreement to take anything out of a session.

Keeping records is a joint responsibility, shared between you and the facilitator. An agreement about how this will be done, by whom and how it will be stored and used should form part of your contracting for the session.

Training and skills

In order for you to engage in the process of clinical supervision you need to be supported to understand the relevance and benefit of supervision to your practice and have a chance to consider and develop the skills required to get the best out of clinical supervision.

An introduction to supervision may be provided by your organisation, in which these concepts as well as what clinical supervision is being offered are explored and explained.

Alternatively a more generic introduction to supervision training may be appropriate, such as the *Introduction to Clinical Supervision e-learning module* that accompanies this toolkit.

What skills can I utilise to make clinical supervision work for me?

Whilst professional skill and experience is not in itself the same thing as reflective skill, you will find that many of the skills and attributes you rely on to be an effective practitioner, will be helpful to you in becoming a reflective practitioner.



Activity

Take some time to think about the skills and attributes you use in your day to day work.

Consider which of those may help you to develop your reflective skills and how you might use them in clinical supervision.

Skills for reflection

As reflection is such an integral part of clinical supervision it is important to consider the skills required to enable effective reflection. These include:

Self-awareness	<ul style="list-style-type: none">• To develop insight into your beliefs and values.• To understand how your behaviour impacts on others.
Descriptive skills	<ul style="list-style-type: none">• To report accurately, clearly and concisely the key elements of a clinical situation.
Ability to explore feelings	<ul style="list-style-type: none">• To describe your own positive and negative feelings.• To put yourself in the situation of patients and colleagues to be able to consider their feelings.
Ability to evaluate	<ul style="list-style-type: none">• To be able to form overall judgement or opinion on what has happened and how you have behaved.
Critical analysis	<ul style="list-style-type: none">• To breakdown the report and question what has happened in more detail including how different aspects relate to each other, and how you influenced the outcome.
Highlight existing knowledge and any gaps	<ul style="list-style-type: none">• To build on your strengths and work on your weaknesses.
Challenge assumptions	<ul style="list-style-type: none">• To notice and consider preconceived ideas about a situation and see beyond them.
Exploring alternatives	<ul style="list-style-type: none">• To be able to consider creative solutions to a problem.• To create a working environment where alternative courses of action can be used.

With commitment and practise you will develop the skills for reflection that have been highlighted. The support of a facilitator during the process of supervision will also promote skills development in this area.

✓ **TIPS FOR PRACTICE**

Developing the skills for reflection is best done through practise, alone or with others. You could write reflective accounts of clinical events or experiences, or use reflective dialogue whilst discussing issues with peers informally or in more structured debrief sessions. Keeping in mind one of the models of reflection described in the *Tools for Clinical Supervision* section (page 31) may help you to focus your reflective activity.

Preparation

To do clinical supervision justice it is important to do some preparation before taking part.

This is the case whether you are involved in individual or group supervision.

Why should I prepare?

Preparation is important because:

- It enables the reflective process to begin prior to the session, promoting the best use of time.
- It helps the session become more powerful in relation to the outcome possibilities and depth of reflection.
- It increases the likelihood of the session feeling useful and worthwhile and so improves motivation.
- It models and communicates a high level of commitment.

How could I prepare?

Your preparation could include:

- Reviewing achievements since the last session.
- Considering how learning from previous sessions has influenced practice.
- Writing a reflective account.
- Thinking about an event or issue to bring to supervision.
- Thinking about a model of reflection to use.

✓ TIPS FOR PRACTICE

On the day of your clinical supervision, try to ensure that you have a few minutes to let go of the busyness of your day before you begin the session. Calming your mind and reminding yourself of the benefits of taking part in an open honest way will be beneficial.

Evaluation

If you are involved in regular supervision it is likely that your organisation and your facilitator will periodically ask you to take part in some form of evaluation.

Engaging in the evaluation process honestly and constructively will be helpful in terms of skills development for the facilitator and service development for the organisation.

In addition it will be beneficial for you to regularly review how the clinical supervision you are taking part in is meeting your needs. By doing this you may be able to take steps to improve what it offers or to ensure that it continues to be valuable.

See the **Resources** section (page 99) for some examples of evaluation tools.

References

- ¹ Care Quality Commission (2013) *Supporting Information and Guidance: Supporting Effective Clinical Supervision*. London: Care Quality Commission
- ² Bond, M and Holland, S. (2010) *Skills of Clinical Supervision for Nurses* (2nd Edition). Maidenhead: Open University Press
- ³ Hawkins, P and Shohet, R (2012) *Supervision in the Helping Professions* (4th Edition). Maidenhead: Open University Press
- ⁴ Cassidy, P (2010) *First Steps in Clinical Supervision – A Guide for Healthcare Professionals*. Maidenhead: Open University Press
- ⁵ Proctor, B (2011) *Group Supervision a Guide to Creative Practice* (2nd Edition). London: Sage

Clinical Supervision: Information for Facilitators

Clinical Supervision: Information for Facilitators

This section offers you the chance to reflect on your skills and experience and how you may need to build on these to take on or develop the role of clinical supervision facilitator.

This chapter does not represent a training course in the facilitation of clinical supervision.

Helen & Douglas House Experience

As a clinical supervision team at Helen & Douglas House we believe that practising the skills required to be an effective clinical supervision facilitator is an essential part of training.

Facilitator training at Helen & Douglas House covers the topics discussed in this chapter and supports the learning of practical skills by being fully participative.

Roles and responsibilities

The position of clinical supervision facilitator is a skilled and responsible one. It is important that it is entered into with an understanding of the level of commitment that is required.

The role is multi-faceted and involves supporting the quality of work being done by participants, being an educator and role model and providing emotional support. There is also a need to motivate and empower participants to take responsibility for the development of their understanding and practice.

Key responsibilities include:

- Preparing for each session by allocating enough time and making the mental space to be able to fully engage in the session.
- Being reliable and available at agreed times.
- Booking an appropriate room.
- Holding the physical space for the duration of the session.
- Negotiating contracts and boundaries.
- Maintaining confidentiality within the boundaries of the law and professional codes of conduct.
- Keeping time.
- Record keeping.
- Maintaining a structure to the sessions.
- Signposting.
- Directing the reflective process through appropriate questioning and challenge.

Contracting

A number of professional bodies identify that it is good practice to put in place a written agreement or contract between facilitator and participant at the outset of clinical supervision sessions.¹

A clinical supervision contract is an explicit agreement of how clinical supervision will take place including who is responsible for what. It should also acknowledge the organisational expectations of clinical supervision.

Although there is a requirement that the content of the contract is agreed by both the participant(s) and the facilitator, it is your role as facilitator to manage the process of coming to this agreement.²

The term contract can sound very formal and binding, it may be helpful for you to describe it to your participants as a working agreement.³

Agreeing the contract is a time for sharing hopes and expectations as well as defining the practical aspects of the clinical supervision arrangement.⁴

What it should include is covered in more detail in the **Information for Participants** section (page 47).

Examples of clinical supervision contracts are provided in the **Resources** section (page 99).



Activity

As a facilitator you may be asked to discuss clinical supervision with potential participants.

You may find it helpful to put together a question and answer or information sheet that you can share with participants.

You may like to consider some of the following questions:

- What is clinical supervision?
- What are the benefits of clinical supervision?
- What can I offer as a facilitator?
- What is my facilitation style?
- What experience, training and qualifications do I have?
- What can participants expect to happen during a session?

Record keeping

Keeping records of clinical supervision sessions support both facilitators and participants to demonstrate that they are engaging in a safe, effective and professional supervisory processes.

Clear records should be kept of clinical supervision sessions; the responsibility for this is shared between the facilitator and the participant. Local policy may define guidelines for record keeping, which may include how records are kept, stored and used. Where there are no such guidelines, it is important to discuss record keeping as part of contracting.

Records should include:

- Time and date.
- Names of facilitator and participant(s) in the session.
- A general outline of the issues discussed, actions planned and outcomes.
- Any general themes emerging from the session.³

In order that participants feel secure with the records kept it is helpful to record issues discussed as broad themes and ideas, using just key words and headings. Similarly, to avoid recording names or information that could specifically identify a named individual. If you need to make 'aide-mémoire' notes for yourself, you should let the participant know that you will do this.

Barriers to engaging in clinical supervision

As a facilitator it is important to be alert to an individual or group of participants' difficulty in engaging in clinical supervision.

There are a number of factors that may contribute to people not engaging in clinical supervision. Some of these may be practical issues such as supervision not being available at suitable times or a constant high workload. Others may be related to personal factors such as fear of being exposed as inadequate, fear of having practice challenged or a lack of trust in the organisation or others. There are some phenomena that can act as barriers for both participants and facilitators alike:

The wings, the halo and the harp

This refers to the belief that clinical supervision has to be perfect, and the high expectations that are present both for supervision and for standards of work. The reality is that on the whole facilitators and participants are 'good enough' and need to learn to feel comfortable with their own fallibility.

The rabbit in the headlights

This phenomena is about learned helplessness, the belief that nothing can be done to improve a situation and therefore nothing should be tried. Clinical supervision itself can engender a change from feelings of powerlessness to an understanding of accountability and a willingness to take action.

The can of worms

This refers to the notion that issues brought to clinical supervision will 'get out of hand', and become troublesome and dangerous. The structures within clinical supervision are designed to promote the discussion of difficult issues in a constructive and healthy way.

Rocking the boat

This refers to the notion that maintaining the status quo is the safest and most preferable option. Clinical supervision is concerned with finding new ways of seeing things, and as such inevitably prompts change.

Nobody knows what it's about

This notion reflects the idea that despite a wealth of literature, there are many people working in the helping professions who don't have an understanding of what clinical supervision is and how it could benefit them. It can also be interpreted as a belief that it is not possible, within our working life, to have healthy, growth sustaining, reflective spaces.



Activity

How can you enhance participation in clinical supervision for those who are not engaging with what is on offer?

Consider how you would respond to the following statements:

“I have been in supervision before and it was of no value.”

“I am more junior/senior than the rest of the group so I will not fit in.”

“I feel anxious about coming.”

“The supervisor is no good.”

“I don’t want to go!”

“My work pattern means that I am never there when the sessions are held.”

“When I went before everyone picked on me, it was too much.”

“I am always too busy to go.”

“I do not get on with (name), other supervisee(s) or supervisor.”

“I am fine, I don’t have any problems so I don’t need to go.”

Self-care

It has already been acknowledged that facilitating supervision is a complex and demanding role.

Because of this it is important to ensure that you are well enough supported to be able to carry out the role effectively and sustainably. In addition to more formal supervision, peer support can be very useful.

Helen & Douglas House Experience

At Helen & Douglas House, as part of the preparation for facilitating a clinical supervision session, facilitators are encouraged to identify a colleague, usually with experience of facilitation, that they can go to directly after the session to debrief if required.

Another recommendation is to make sure there is time after the session for some reflection. A chance to capture what seemed to go well, helpful questions or interventions and also any difficult moments, will help you develop your practice. Recording these in a personal reflective journal may be useful.

To meet the demands of the role facilitators at Helen & Douglas House are encouraged to schedule an hour and a half for each hour of actual clinical supervision. This supports being able to appropriately prepare for the session and enable the possibility of debrief and time for reflection.

Participating in your own clinical supervision

Participating in clinical supervision in relation to your role as a facilitator is vital. It will support you to understand your emotional responses to the challenges of the role. It will also help you to think about new strategies or approaches to your practice and to understand where you may need to develop your skills.

It is worth noting that you will need to be involved in clinical supervision in relation to both your day to day practice and for your role as a facilitator.

Preparation

As a facilitator an ability to communicate your focused presence for the duration of a session is fundamental.

As such it is important to be able to leave the demands of the rest of your day's work outside the door of a clinical supervision session. In order to do this successfully, you will need to develop your own mechanisms for letting go of demands on your time and thoughts that your other roles present.

If the session is one of a series with an individual or fixed group then it is also important to look back at notes of previous sessions as it may be useful to reflect on what has happened since the previous session and how helpful any agreed actions have been.

Helen & Douglas House Experience

Facilitators at Helen & Douglas house are encouraged to give themselves 15 minutes before a session to mentally arrive in a way that works for them.

Some choose to step outside into the garden, others to find somewhere quiet to focus on the intentions for the session, to visualise a positive outcome, or re-familiarise themselves with a framework or process they may want to use. It may be helpful for you to think about how you could achieve this.

Training and skills

Starting out as a clinical supervision facilitator can be a daunting experience. It can be helpful to spend some time reflecting on this new role, considering what you will be able to bring to it and any areas of your skills and knowledge that you might need to develop to support the facilitator role.



Activity

Reflecting on the way you wish to approach the role, can help you to feel clearer about what will be involved and more confident in the transferable skills you already possess.

Take some time to reflect on some of the questions below:

- What is taking you in this direction?
- Are you naturally drawn to it?
- Is this a new requirement of your role?
- How does your past experience of clinical supervision affect your motivation?
- What skills and experience do you already possess to support you to take on this role?
- Which areas of experience will you be drawing on?
- Which skills do you feel need development?

Answering some of the questions above should support you to find the training that best suits your needs.

Courses aimed at learners at many levels are available from 2 day informal skills-focused courses to post-graduate diploma courses. There is also an abundance of literature written on the subject which can support your practice.

Helen & Douglas House Experience

At Helen & Douglas House we firmly believe there is no substitute for the practical opportunity to try out facilitation skills for clinical supervision in a supportive learning environment.

What skills and attributes can I develop to be an effective facilitator?

Some of the key skills and attributes of effective facilitators identified in the literature are highlighted below.

Facilitators need to develop skills to become:

- **Active listeners** – able to listen in a way that communicates presence and intention to really hear and understand what a person is trying to communicate.
- **Expert communicators** – with the ability to recognise that, in the role of facilitator, they are likely to be listening more than speaking. This will involve asking the right kind of questions in a given situation to support the reflective process.

Driscoll⁵ suggests among other things key attributes of effective facilitators are:

- An ability to work collaboratively.
- Integrity.
- Honesty.
- Sensitivity.
- Self awareness.
- Credibility.
- A sense of humour.

Cassedy³ describes four core conditions which facilitators need to communicate to enable effective supervision. These are:

- **Empathy** – the ability to “feel with” the other person, grasping and participating in their thoughts without taking them fully within ourselves.
- **Genuineness (or congruence)** – you are in the role of supervisor but are being yourself.
- **Acceptance (or warmth)** – recognising and valuing the individual response to a given situation.
- **Unconditional positive regard (or respect)** – acceptance of the participant unconditionally and non-judgementally.

Using effective questions to facilitate clinical supervision

Effective questioning goes hand in hand with effective listening. Together they open up opportunities for participants. It is important that you do not go into a clinical supervision session with pre-prepared questions as that will prevent the participant from maintaining control over the content of the session or prevent the session to flow naturally.

Questions	Response	Examples
Do, Have, Has, Is, Are	Limited or 'yes' or 'no' answers	<i>Have you learned anything?</i> <i>Are these the only choices available to you?</i> <i>Is there a barrier in your way?</i>
Who, When, What, How, Where	Open and encourages participant to expand on their thoughts	<i>What have you learned from this situation?</i> <i>What other choices are available to you?</i> <i>How would you describe the barrier(s) in your way?</i>
Why	May evoke defensive response	<i>Why did you do that?</i> Can be changed to: <i>What did you aim to achieve when you did that?</i>
Follow the participants interest	Participant feels valued and works toward own solution	<i>Tell me more about...</i>
Clarifying	Facilitates understanding	<i>I think what you are saying is..., is that correct?</i>
Incisive (what if...)	Helps move a participant on when they are stuck	<i>What, if you were performing at your best, would you do?</i>

As a facilitator you will need to use curiosity and skilful questions to promote a shared understanding, identify values and goals and enhance the self awareness of the participant(s). Questions need to be clear but probing. In your role as facilitator you will need to remain sensitive to the participant who can feel vulnerable if they have not addressed an issue before.

Questions	Response	Examples
Check commitment	Assigns participant responsibility to take action	<i>What will you do?</i> <i>When will you do it?</i>
Powerful	Can get to the heart of a problem	<i>Where will this lead?</i> <i>What is stopping you?</i>
Enquire	Explores values, beliefs or behaviours in situations	<i>What are you tolerating?</i> <i>What motivates you?</i>
Reframe negative to positive	Moves away from negative self talk or criticism of self or others	<i>Why is this happening to me?</i> Can be challenged by asking: <i>How can you turn this situation around?</i> <i>How can you make it work to your advantage?</i>
Challenge	Raises participant's awareness	<i>What are you afraid of?</i> <i>How is this affecting you on a daily basis?</i>



Activity

As a facilitator you will need to be able to ask questions that promote reflection, appropriately challenge and support learning.

You may find it helpful to think of your questions as a set of keys, that you will use to help the participant to unlock the learning from their experience and open a door to a new understanding.

Take some time to think about your own way of asking questions. Consider how you might feel comfortable asking questions, think about the words and phrases you might use. You may wish to do this in a more general way or to consider how you would respond to a specific scenario that has been brought to a clinical supervision session.

Evaluation

To grow and develop in your role as a clinical supervision facilitator it is important to make time to critically evaluate the work that you do.

Self-assessment may be useful and a number of self-assessment questionnaires have been developed.^{3,4}

Seeking feedback from the participants will also help to inform your understanding of your strengths and areas for development. This may be done face to face, at a review session or at arm's length, via questionnaires.

Seeking feedback from colleagues and your own clinical supervision facilitator will also help you to get a balanced view of your skills and performance. Again this may be requested face to face or via questionnaires.

Some examples of evaluation/feedback questionnaires can be found in the **Resources** section (page 99).

Development

Your own clinical supervision will help you develop your facilitation skills and help to ensure that you operate within the boundaries of your competence.

Reflecting on your strengths and what you find more challenging will help you focus on areas for development. There are also numerous courses at differing levels that you may wish to consider.

Aide-mémoire for facilitators

The checklist below may be a helpful reminder of the practical and process issues that you will need to address when facilitating clinical supervision.

- Discussing practicalities of clinical supervision – time, place, frequency etc.
- Confidentiality.
- Record keeping.
- Developing a clinical supervision contract.
- Discussing expectations of the session/process (goals and objectives).
- Building a rapport.
- Establishing a respectful relationship.
- Maintaining focus and timing of sessions.
- Action planning to ensure goals and objectives are achieved within an identified timescale.
- Agreeing what will be discussed at sessions.

6

✓ TIPS FOR PRACTICE

- Listen actively to what the person is saying to you.
- Use your facilitative skills.
- Ensure the participant(s) talk(s) from their personal experience.
- Do not become defensive (especially if the challenge, anxiety, anger or fear is aimed at you).
- Do be prepared to ask for help: If you are struggling with a situation that has arisen in clinical supervision you are facilitating, speak to someone else to reach an understanding of what needs to happen.

If it is becoming difficult to hold the time and space consider solutions such as:

- Changing the times of clinical supervision.
- Using external supervision.
- Moving supervision groups off site.
- Telephone supervision or Skype.

6

References

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Clinical Supervision: Information for Managers & Organisations

Clinical Supervision: Information for Managers & Organisations

“Clinical supervision is an invaluable tool for improving practice, supporting staff and maximising the emotional well-being of staff and volunteers who are involved in challenging roles. For it to work well it needs to have organisational support and individual commitment and buy in. I commend it as a tool to all people who work in patient facing roles.”

Clare Edwards, Director of Clinical Services, Helen & Douglas House

Every team and organisation is different, and will have different needs. Getting supervision ‘right’ is a difficult task, and it is likely that no one model or ‘off the shelf’ package will be the perfect fit.

Investing time and thought into tailoring an approach to ensure that the clinical supervision on offer or that is developed meets the needs of your organisation will reap the best rewards for all.

This chapter offers you the chance to consider the clinical supervision needs of your own team or organisation and the policy development and governance processes that will help to ensure that it is effective.

Getting it right for *your* team or organisation

Those involved with organising and managing clinical supervision for a team or an organisation will need to consider:

- The unique needs and circumstances of that team/organisation.
- The starting point – whether starting from scratch or refreshing the existing provision.
- The complexities of introducing and managing change.

Comparing and contrasting other professional support to clinical supervision



Activity

Take some time to think about how clinical supervision compares to other forms of professional support and development such as mentoring, coaching, consulting and counselling.

- Consider the elements of each that are the similar as well as the differences.
- Compare your answers to the table on page 74.

Comparing and contrasting other professional support to clinical supervision

Clinical Supervision	Mentoring
<p>Similarities</p>	<ul style="list-style-type: none"> • Both mentoring and clinical supervision are interactive processes. • The mentor/supervisor guides and facilitates the process. • Reflection is part of the process. • Learning is focused on the individual doing something, or behaving differently.
<p>Differences</p>	<ul style="list-style-type: none"> • The mentor is usually an expert in the same professional area as the mentee. The clinical supervisor needs to be skilled in facilitating and does not need to be an expert in the clinical area or profession of the supervisee. • The mentor can make suggestions and give advice as part of their role. A clinical supervisor facilitates understanding. • Mentoring may involve a judgement to indicate if the mentee has achieved specific competencies. Clinical supervision is non-judgemental.

Consulting

- The client will approach the consultant/supervisor to undertake a specified role.
- The process is usually time limited.
- Process is analytical in nature.
- As a result, changes usually occur in the way things are done.

- Areas of work are usually specified by the organisation and led by the consultant. Clinical supervision is led by the individual and facilitated by the supervisor.
- The consultant will approach and discuss relevant information with all the key stakeholders. Confidentiality applies within the clinical supervision situation.
- The process usually involves the consultant giving advice and making recommendations. Clinical supervisors work so the client discovers their own answers or questions.

Counselling

- Clinical supervision and counselling are non-judgemental processes.
- Clinical supervision and counselling focus on the holistic aspects of a person's life.
- The agenda is set by the client and facilitated by the counsellor/clinical supervisor.
- Counsellors/clinical supervisors do not need in-depth professional knowledge about the working environment.

- Counselling may involve a physical or psychological medical diagnosis. The focus is on the meaning behind the words and actions. Clinical supervision is about changing clinical practice and focus is applied as much on the patient/client being cared for as the practitioner.
- A counsellor gains a strong insight into how the past has created someone's present. Clinical supervision acknowledges the past has happened but the focus is on the present and future.
- Counselling may continue for many years and involve ongoing discussion around key themes. Clinical supervision is usually time limited.

Leading by example

In order for clinical supervision to become embedded in the culture of workplaces, it needs to be supported and endorsed by those who manage teams and services. There is a need for a commitment to clinical supervision that is modelled by leaders and managers in their own practice, and which is supported by adequate resources and governance structures.

Statutory requirements for the provision of clinical supervision

There are currently no statutory requirements or national guidance about clinical supervision provision in health care settings.

Whilst clinical supervision is regarded as an essential component of safe and effective professional practice by a range of professional bodies, in health care it is recommended that provision is developed and governed at local level.¹

The Care Quality Commission states:

“Clinical supervision should take place regularly. The frequency and duration should be adequate to ensure safe and competent care for people who use services. The most appropriate supervision arrangements for a member of staff are determined by a number of factors including their experience, the type of work they carry out and their individual needs.”²

This suggests that organisations need to develop a flexible approach to the provision of clinical supervision.

Roles and responsibilities

Whilst much of the responsibility for what happens during and as a result of clinical supervision is held by individual participants and facilitators, it is important to be clear about who has overall responsibility for the provision of clinical supervision within your team or organisation.

“The registered provider or manager must have suitable arrangements in place to ensure that people employed for the purposes of carrying out the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to people who use services safely and to an appropriate standard. An effective system of clinical supervision is one way of ensuring this.”²

The person leading on clinical supervision in your organisation will be required to lead collaborative and inclusive work with the staff and management teams to plan, implement and evaluate clinical supervision.

It is equally important to be clear about the responsibilities of participants and facilitators, these are examined separately in the sections **Information for Participants** (page 43) and **Information for Facilitators** (page 55).

Contracting

For those responsible for organising and managing clinical supervision provision it is important to consider contracting at two levels.

Firstly, a clinical supervision policy represents a contract between the organisation and those who will facilitate and participate in clinical supervision. There is further information about this in the ‘Preparation’ section of this chapter (page 83).

Secondly, the structures and requirements that are put in place around clinical supervision sessions will ensure that clinical supervision is delivered in a safe, effective and professional way, protecting and supporting both facilitators and participants.

Further information on contracting for clinical supervision can be found in the sections **Information for Participants** (page 47) and **Information for Facilitators** (page 58). Example contracts can be found in the **Resources** section (page 99).

Record keeping

Maintaining clear and accurate records of clinical supervision is the fundamental way of demonstrating safe, ethical and effective supervision practice.

However, keeping records of clinical supervision can be a sensitive and contentious issue, and there is a lack of clarity regarding the legal aspects of this.

It is suggested that where clinical supervision is a requirement of the employment contract, and the employer resources the provision of clinical supervision, the employer owns any records and has a right to access records of attendance. These records may be accessed as part of disciplinary proceedings involving either facilitator or participant, where clinical supervision would be a relevant factor. It is possible, although highly unlikely, that these records could be subject to subpoena by a court of law.³



Activity

Take some time to think about the records of clinical supervision kept within your organisations.

Consider:

- What are the expectations regarding record keeping set out in policy or guidelines?
- How can best use be made of records kept for the purposes of audit and evaluating the provision of clinical supervision?
- Who owns the notes and records from clinical supervision?
- Who has access to the records of clinical supervision?
- Where are the records stored, how and for how long?

Barriers to engaging in clinical supervision

Whilst it is recognised that there are many positive reasons for providing clinical supervision, it is also suggested that there is a 'hidden picture'.

Underlying the benefits of clinical supervision, is a subtext of potentially conflicting and destructive elements that discourage or prevent individuals engaging in clinical supervision⁴. It is important to communicate transparency around all aspects of clinical supervision, in order to reassure facilitators and participants that clinical supervision is not being used as a management tool, or a way to judge or criticise staff.

It is also helpful to acknowledge that other hidden resistance to clinical supervision may arise from individuals own anxieties about the emotional aspects of clinical supervision. It is vital that facilitators are supported to develop the skills needed to form effective and collaborative supervision relationships.

Training and skills

Clinical supervision itself can be a part of a workforce development programme. In order to provide clinical supervision that is safe and effective, good quality training must be provided for both participants and facilitators.

Training for participants

Staff participating in clinical supervision will need protected time to undertake appropriate training. This training could be face-to-face or via e-learning packages. There are many training providers offering a variety of generic training options that introduce the participant to the concept of clinical supervision.

It is also possible to develop tailored introductory learning sessions for staff that more directly reflect ethos, policy and provision at a local level. This can be developed 'in-house' or in collaboration with external training providers.

Helen & Douglas House Experience

Helen & Douglas House has produced an *Introduction to Clinical Supervision e-learning module* to accompany this toolkit which uses reflective exercises to encourage participants to engage with the subject on a personal level and an end of module test to assess learning.

Training for participants should, as a minimum, include:

- An overview of the concept of clinical supervision.
- A guide to using models for guided reflection.
- Time and space to explore what clinical supervision might mean to them as participants and how they might use it.

Training for facilitators

Managers and clinical supervision leads cannot assume that professional skills and experience are the same as facilitation skills. All those in the role of facilitator will need protected time, support and resources to access appropriate training and to prepare for the role of facilitator.

Training for facilitators may be sourced from any number of providers. There are a range of courses available from 2 day informal skills-focused courses to post graduate diploma courses. Choosing a course will involve considering the needs of the team/organisation alongside the learning and support needs of the individual facilitators.

It is recommended that facilitators attend update and refresher training, in addition to attending their own clinical supervision in respect of their facilitator role.

Taking on the role of clinical supervision facilitator presents opportunities for professional development for experienced members of staff. However in some organisations there may not be the capacity or desire to develop the skills from within the staff teams.

For this and other reasons you may choose to use external clinical supervisors to meet the clinical supervision needs of individuals and teams within your organisation.

There are likely to be many well qualified and experienced practitioners, often individuals working on a freelance consultancy basis, who offer these services local to your organisation. There will be variations in areas of expertise, levels of training and professional fees which you will need to explore. Care should be taken when commissioning this option that the clinical supervision practitioners involved are helped to really understand your organisation and the needs of staff in it.



Activity

Take some time to think about the potential facilitators in your team/organisation.

Consider:

- How they might make the journey to facilitator.
- What might they need along the way.
- How might that be supported.

Thinking specifically about how this development could be mentored, supported and resourced could form the basis of a clinical supervision strategy.

Training for managers and clinical supervision leads

It is recommended that managers undertake training related to clinical supervision, in addition to participating in their own clinical supervision in support of their roles.

The person with overall responsibility for clinical supervision should ideally have extensive experience of facilitating and participating in clinical supervision as well more in depth training.

It may be that at present there is no one in your organisation with this depth of experience. If this is the case the person seeking to lead clinical supervision within your organisation will need, at minimum, a firm belief in the potential benefits of clinical supervision and a willingness to develop skills and knowledge through training.

Preparation

It is important that clinical supervision provision is underpinned with associated policy, procedures and guidelines.

These support the implementation, review and evaluation of clinical supervision provision.

They should address:

- Purpose and function of clinical supervision.
- How clinical supervision contributes to the overall aims of the team or organisation.
- A statement on anti-discriminatory practice.
- Who is responsible for clinical supervision within the team/service/organisation.
- Which roles or groups of staff are expected to participate in clinical supervision.
- Organisational and professional expectations – minimum requirements for attendance at clinical supervision.
- Clear guidance on the type of confidentiality that can be expected and guaranteed.
- What is available – describing the menu of clinical supervision opportunities.
- Training requirements for both participants and facilitators.
- How records of clinical supervision will be kept, stored and used.
- How clinical supervision will be evaluated.⁵

Helen & Douglas House Experience

At Helen & Douglas House we have created a clinical supervision strategy.

It is a document which serves as a statement of the value the organisation places on clinical supervision and a plan for developing a culture of transparency in which supervision is embedded across the organisation at all levels. The articulation of our commitment to the process and the definition of our desired outcomes helps us stay focused as we grow and develop the provision of clinical supervision.

Evaluation

Evaluating clinical supervision is a formal process of gathering evidence, reviewing it and making action plans.

Evaluating clinical supervision consists of both informal evaluation after each session and more formal structured evaluation usually between four and six monthly. How this is done will vary from facilitator to facilitator and is addressed in more detail in the **Information for Facilitators** section (page 68).

There is also a need for broader organisational evaluation.

It is recommended that clinical supervision is formally evaluated annually. This should include:

- Review of clinical supervision policy and strategy.
- Review of training undertaken and training needs analysis.
- Feedback from participants and facilitators.
- Evidence of uptake of clinical supervision.
- Evidence of improvements to practice.
- Evaluation of the models and frameworks used.
- Evaluation of the themes/issues discussed.
- Action plans for developing clinical supervision.

Clinical supervision provision may need to be adjusted over time to accommodate more or less participants, to fit around emerging regular commitments or for other reasons unique to your organisation and teams.

Evaluating clinical supervision should be an inclusive process that seeks feedback from staff about practical aspects such as timing of sessions, and also about experiential aspects such as how helpful they have found sessions.

Where records are kept, evaluating the themes discussed helps to identify potential areas for development and support within the teams. This allows managers to respond to the stresses and difficulties staff are experiencing in their work.

Development

Establishing and embedding clinical supervision is an ongoing process.

Strategic and operational commitment needs to be evaluated, refreshed and renewed in order that clinical supervision continues to meet the needs of a developing work force in a changing landscape.

Clinical supervision is at the heart of a learning culture. It is one way to ensure that the learning and development of individual members of staff, supports teams and organisations to breathe, learn and grow.⁵

Embracing the wider learning from clinical supervision requires that we consider what has come about as a result of clinical supervision.

Questions to consider:⁵

- What has been learnt that wasn't known before the supervision took place?
- What has been learnt that couldn't have been arrived at as individuals?
- What new capabilities have been generated as a result of supervision?
- What new resolve or direction has come about?

One of the key aspects of organisational development in relation to clinical to supervision is to create pathways where learning is shared.

Relating clinical supervision to effective clinical governance, McSherry suggests:

“Quality improvement and lifelong learning can only be achieved by providing staff with support, resources and time to reflect on their experiences and practices. Investing in the development of a clinical supervision framework as part of clinical governance will ensure that individuals, teams and the organisation's staff can develop and reflect and improve their practice singly and collectively.”⁶

A process driven approach to developing clinical supervision

When developing clinical supervision, either introducing or upgrading current provision, it is helpful to follow a process as set out below:

- 1 Be curious** – what clinical supervision is already happening, what is working well, how can those involved be valued and included in the way forward?
- 2 Awaken interest** – take an inclusive and collaborative approach to writing a strategy and policy.
- 3 Test the water** – initially work with small groups of interested individuals to try out the new ideas, training sessions etc.
- 4 Recognise change process** – offer support that will empower individuals to adapt and change.
- 5 Provide the equipment** – training and development for participants and facilitators to support their new or changing roles.
- 6 Review and evaluate** – developing clinical supervision should be an ongoing cycle of development and review.⁴

✓ TIPS FOR PRACTICE

When designing and implementing a programme of clinical supervision, the following factors have been linked to success:

- A multi professional model that enhances personal and professional support and development.
- A flexible and practical approach to staff support of which clinical supervision is one component.
- Organisational sign up to ensure the implementation of clinical supervision is sustained.
- Named lead(s) for clinical supervision (strategic and operational).
- Access to skilled clinical supervisors (both internal and external).
- Support for supervisors.
- An expectation that clinical staff attend clinical supervision or are able to demonstrate they engage in formal reflective learning.
- Protected time to ensure clinical supervision is prioritised.
- An approach that offers a balance of support and challenge.
- Learning that is shared across the network.

7

Helen & Douglas House Experience

The recommendations in the tips for practice box above have informed the development of clinical supervision provision at Helen & Douglas House.

References

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Clinical Supervision at Helen & Douglas House: Our Story So Far

Clinical Supervision at Helen & Douglas House: Our Story So Far

Clinical supervision has been central to the model of staff support for more than 30 years of care at Helen & Douglas House. Managers and the clinical teams have recognised the value of and practised elements of clinical supervision since the very beginning.

Our experience has taught us that Clinical Supervision is not additional, but integral to the care we provide at Helen & Douglas House.

Clinical supervision contributes to supporting and investing in staff at all levels. It enables them to continue to offer the highest standard of patient care, demonstrating compassion and dignity in their work. In addition the investment in the provision of clinical supervision communicates the value and respect the organisation has for each member of the team providing care to patients and families at the most difficult of times.

A clinical supervision toolkit

In 2010 Helen & Douglas House was commissioned to develop a clinical supervision resource by the Thames Valley Children's Palliative Care Network. This provided impetus for us to reflect on our experience in clinical supervision and to work collaboratively with colleagues across the region to create the *Helen & Douglas House Clinical Supervision Toolkit*.

The project gave us the opportunity to review our commitment to clinical supervision and refresh our approach to training and provision.

The Helen & Douglas House menu of clinical supervision

Through reviewing our practice and consulting with staff we feel we have established an innovative way of approaching clinical supervision in the organisation.

We have created a menu of supportive interventions that can be accessed by members of the team. However the mainstay of provision is delivered through drop-in group supervision sessions (see pages 16-17 in the section 'How might clinical supervision be delivered?').

Our approach is inspired by our specialised health care setting but may be applicable in many others.

How we do it

- We offer access to regular group clinical supervision which is extended to all staff and volunteers with a patient facing role (clinical supervision is offered to non-patient facing staff on an as required basis).
- Weekly drop-in clinical supervision sessions are facilitated by one of a pool of trained staff from across different clinical disciplines.
- All those facilitating clinical supervision have taken part in our participative in-house two day facilitators training. Training for facilitators is tailored to the Helen & Douglas House philosophy and 'menu' of clinical supervision. The course focuses on experiential learning, offering facilitators an overview of relevant theory alongside the opportunity to practise and develop facilitation skills.
- Our facilitators are required to attend their own supervision in relation to their role as facilitators and to take part in update training.
- All staff and volunteers receiving clinical supervision have the opportunity to take part in our introduction to clinical supervision training to enable them to get the best out of the clinical supervision sessions they attend.
- The clinical supervision menu, which is explained at introductory clinical supervision training for participants, clearly sets out the comprehensive support that is available for staff to access.
- Our clinical supervision policy clearly defines the expectations of all staff to engage in clinical supervision.

Models and frameworks we have adopted

At Helen & Douglas House we use Proctor's Functions of Clinical Supervision model to define the purpose of supervision. The focus on learning, accountability and support is aligned with the philosophy of clinical supervision adopted by the organisation.

As an overarching framework we introduce facilitators to the Hawkins and Shohet's *Seven Eyed Supervision Model*¹. This model promotes a holistic approach to clinical supervision. It places the patient at the centre throughout the reflective process. This is aligned with the patient/family centred philosophy of care at Helen & Douglas House.

Facilitators are then encouraged to develop their own style, using reflective models or frameworks to support the process of reflection within the sessions they facilitate.

Why this way of offering clinical supervision works for us

The clinical supervision provision at Helen & Douglas house reflects the holistic, creative and flexible ethos that is the hallmark of palliative care. The drop-in groups mirror closely the way the care team works – each shift is unique, made up of a group of colleagues supporting a group of patients. Each episode of drop-in group clinical supervision is also unique.

Taking on the role of clinical supervision facilitator provides learning and development opportunities for our staff.

The wider menu of clinical supervision offers team members the opportunity to access the kind of supervision that will be most effective for them at the time that they need it.

From an organisational perspective, it enables us to provide a comprehensive clinical supervision package to a large number of people in a cost effective way.

How our staff teams experience the provision of clinical supervision at Helen & Douglas House

The following quotes are extracted from a focus group session during which participants were invited to share their thoughts and experiences of clinical supervision at Helen & Douglas House.

"I think it would be sorely missed if it wasn't here now, it would be very sad not to have it."

Care team member

"Some people do say that they don't need supervision, but I think sometimes that's the nature of their personality – they'd much rather do peer support rather than formally sit in a group. That's the benefit of having the 'menu' that you can dip in to various types of supervision."

Care team nurse

"I find that sometimes you could be doing your role and something could have cropped up in that which hasn't affected you, and it's being aware that other people have been affected by it. I think that's a really important thing for the team."

Care team member

"We've had a couple of clinical supervisions so far...it's a very good emotional back-up for us. Parents open up to us and sometimes that's quite hard for us, because we don't know the situation that goes on down at the end of the corridor (in the care areas) and so for us to talk about it emotionally in clinical supervision is good."

Catering team member

"I think it gives you a chance to focus on how you think things could be better, as well. If you know you've got the [clinical supervision] meeting coming up, it makes you maybe step back and think "maybe that could be better". Whereas if you haven't got that you just continue to do the same thing without really having the chance to evaluate how things are going, what you're doing."

Care team volunteer

Strategy and policy framework

The Helen & Douglas House Clinical Supervision Strategy and the resource commitment required to action it, is a reflection of the high priority the organisation places on staff support and development through clinical supervision.

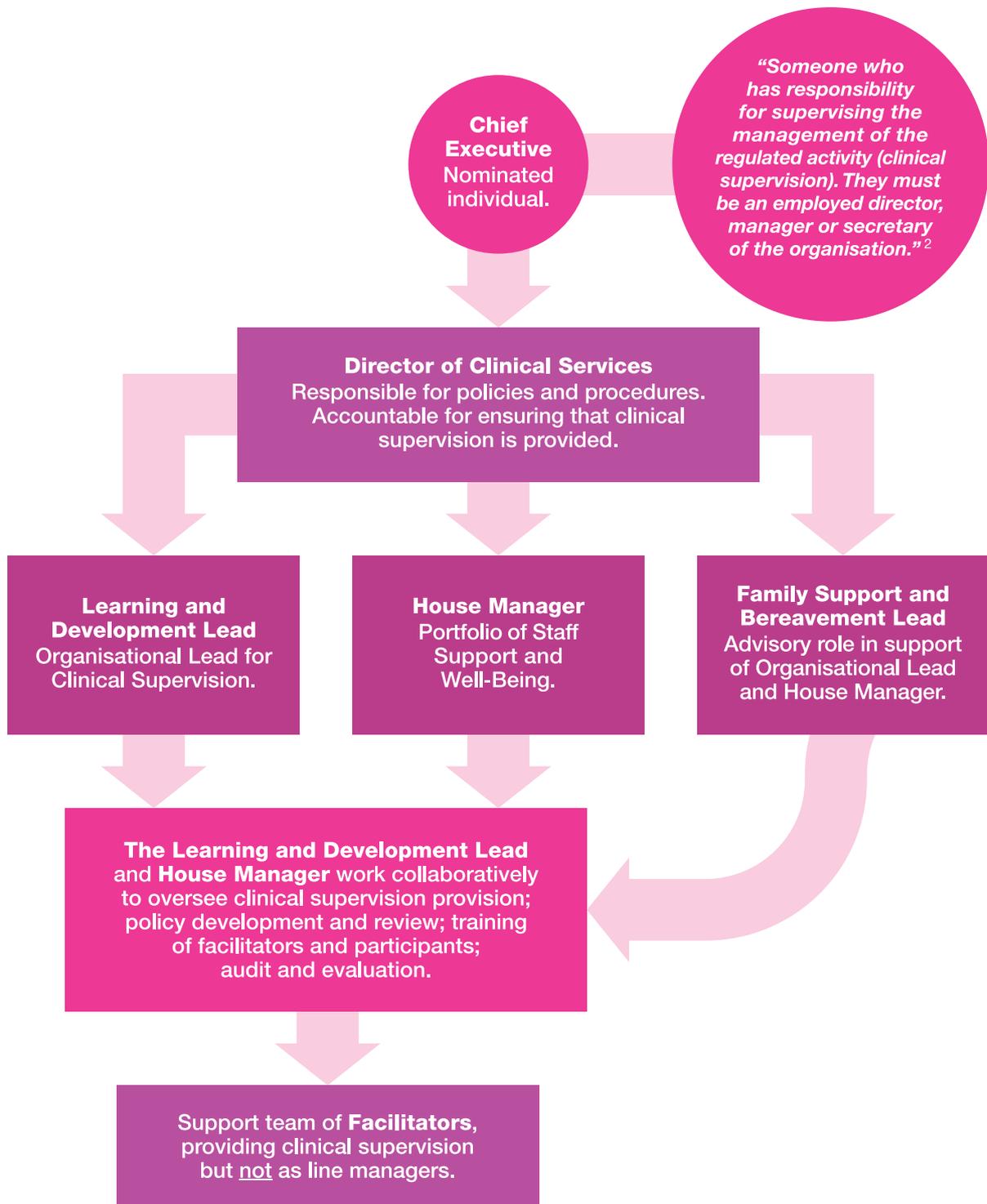
The strategy encourages the development of a culture which visibly values clinical supervision at all levels, with the aim of fostering individual engagement in the process.

In order to deliver the clinical supervision provision at Helen & Douglas House it has been vital to have a policy in place which puts clinical supervision formally at the heart of and across the organisation.

The Helen & Douglas House Policy for Clinical Supervision sets out what provision is available and for whom, and has provided a vehicle for us to set out our expectations in regard to the required commitment from all those involved.

A structure for delivery

A key to the effective delivery clinical supervision at Helen & Douglas House has been the clear definition of roles and responsibilities. These are outlined in the chart below:



Evaluating our clinical supervision provision

The provision of clinical supervision outlined on page 95 represents some new ways of working. We are in the process of evaluating the impact of the changes, particularly in relation to the drop-in groups.

A part of this evaluation has been to undertake a staff survey which highlighted the following:

- Almost all respondents were aware of and could define why clinical supervision was offered to patient facing staff and volunteers.
- A large majority of the respondents were comfortable with the fact the facilitators for each group were not advertised in advance and that the facilitator may be from a different area of the organisation to them.
- A majority of respondents felt that clinical supervision helped them manage the stress of their work and helped them cope with the impact of their work although some did not feel it helped with either of these things.
- Many staff reported that they valued the clinical supervision on offer at Helen & Douglas House.
- Many staff still found it challenging to get off a shift to be able to attend clinical supervision sessions.³

Through the review process we aim to consolidate and embed what we do well and look at how we can improve on what may be working less well.

Building on strong foundations

We aim to continue to grow and develop clinical supervision at Helen & Douglas House. Through reviewing our provision and listening to what our team members tell us about their experience of clinical supervision we can continue to use innovative approaches to meet their needs for staff support and development.

We have a strong core of clinical supervision facilitators, trained from within the various teams at Helen & Douglas House. We are keen to support the learning and development of these individuals through offering updates and access to advanced training.

We have developed an ***Introduction to Clinical Supervision e-learning module*** which we are keen to disseminate along with this second edition of the toolkit.

Aspirations for the future

We hold firmly to the belief that clinical supervision isn't a task to be undertaken or a process to be submitted to; rather it is a way of being in professional practice, which fosters a willingness to be changed by our experiences of caring. Helping us to learn and develop as an integral part of day to day working life.

As we look to the future, our key focus will be to keep listening. We can do this through evaluating the provision of clinical supervision and training, and hearing feedback and ideas from team members.

Alongside this we will continue to attend to the changing needs of our staff and volunteers, developing clinical supervision accordingly.

We will continue to provide both update and facilitator training, so that through adequate succession planning, we maintain a pool of skilled facilitators and participants equipped to engage in clinical supervision.

We look forward to reaching out beyond our own organisation by responding to interest in the ***Introduction to Clinical Supervision e-learning module*** and facilitator training packages.

We feel that we have travelled and will continue to travel a long road, with many new beginnings. We recognise that we are on a journey in clinical supervision.

Wherever you are in your own journey with clinical supervision, we are pleased to have shared a little of that journey with you and we wish you well.

References

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Clinical Supervision: Resources

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Contracting

A template for a clinical supervision contract

Name of supervisee:

Name of supervisor:

Review date:

This usually occurs every six sessions and it is the point when the supervisor or supervisee can terminate the supervisory relationship. This review often coincides with the formal evaluation.

Frequency and time of meetings:

Agree regularly spaced times to meet with the individual or the group in line with work and diary commitments.

Venue:

Find a venue with a private area where you will not be disturbed.

The purpose of supervision:

This is the reason why the supervisee wants supervision and what they wish to gain from the sessions. The purpose may include issues that relate to all aspects the clinical environment including:

- *Policy issues, service user/patient issues, team/staff issues, innovation and development issues, care planning/casework, clinical/personal issues, reflection/evidence, training and development.*
- *Ensure the statements are SMART (Specific, Measurable, Achievable, Realistic and Timed) so they can be measured as part of the evaluation process.*

Confidentiality

Confidentiality is not a 'vow of silence'. This section should clearly state the extent of confidentiality and when and how it might be broken.

As supervisee and clinical supervisor, we agree to the following:

This section includes a statement of commitment by clinical supervisor and supervisee to achieving aims. You can include the responsibilities of the supervisee and supervisor here. Discuss and develop together as part of the intake session. This section promotes the shared understanding of clinical supervision, a clear mechanism for working together, including record keeping, and a commitment to the supervisory relationship.

Monitoring/Evaluation

This involves informal evaluation at the end of each session. What was helpful about the session and what was difficult or less helpful about the session. Formal evaluation should be conducted regularly which will review the process including learning achieved, level of support and challenge of supervision; and individual feedback to supervisee and the supervisor.

Duration of the supervision relationship:	
Signed and dated:	
Supervisee:	
Supervisor:	

An example of a clinical supervision contract between a facilitator and an individual participant

1 The content of the clinical supervision session will be to:

- Review clinical practice.
- Discuss current problems/concerns.
- Discuss issues related to professional development.

The normative, formative and restorative functions of clinical supervision will be used as a conceptual framework.

2 The clinical supervision session will be held every for approximately hour(s)

3 Confidentiality between both supervisor and supervisee(s) will be strictly maintained in order that it will not be breached outside of the session unless otherwise agreed by both parties.

Confidentiality clause: All issues discussed will be in confidence, unless there is anything disclosed that affects the well-being of the supervisee or is detrimental to the patients, professional practice, the team or the organisation.

In the event of disclosure of information that constitutes malpractice or places the patient or organisation at risk, action will be taken to inform the relevant line manager.

4 A record of attendance will be kept and may be provided for monitoring and audit.

Written records of supervisory sessions may be recorded by the supervisor and agreed by the supervisee. Confidentiality and privacy will be maintained in accordance with the professional code of conduct. Both parties may also use a personal reflective journal.

5 We both agree that regular supervision is a commitment and should be cancelled only in the case of illness or crisis. Notice will be given and it is the responsibility of the person who cancels to rearrange the session.

6 Both parties will participate in formal evaluation of supervisory meetings after months. Evaluation feedback will be used constructively and may be disclosed to other parties.

7 In the event of the supervisory partnership being ineffective or any difficulties arising, either party can choose to terminate the contract after full discussion and agreement of both parties.

8 In the event of termination of a supervision contract it is the supervisee's responsibility to approach and agree an alternative supervisor and supervision contract.

9 We agree to abide by the terms set out in this clinical supervision contract.

Supervisee

Name:

Date:

Signature:

Supervisor

Name:

Date:

Signature:

Based on: Cassidy, P (2010) *First Steps in Clinical Supervision; a Guide for Healthcare Professionals* pp.40-41. Open University Press

Another example of a clinical supervision contract between a facilitator and an individual participant

We each agree:

- To meet at regular prearranged intervals for one hour.
- We will prioritize the sessions and inform each other as soon as possible if attendance is not possible, and arrange a following meeting.
- We will meet for six sessions and then review.
- The focus will be on any aspect of the supervisee's work.
- We will both abide by the clinical supervision policy of the organisation by which we are employed.

My role as a supervisee is to:

- Uphold ethical guidelines and professional standards with the aim to ensure and improve quality practice.
- Build a working relationship with you.
- Attend punctually supervision sessions that we organise.
- Help you to identify my work goals and agenda for supervision.
- Be open to feedback, change and consideration of alternative/improved methods of practice.
- Endeavour to complete tasks that we have agreed upon each session.
- Help me build my confidence, capabilities and skills in my work role.
- Express my thoughts and feelings about supervision and to give feedback to you.

I have read and agree to the organisation's aims, objectives and policy on clinical supervision, which includes the guidelines on confidentiality and record keeping. I am familiar with its general operation.

This contract can be reviewed at any time upon my request to you and it will be reviewed annually.

Name: **Date:**

Signature:

My role as a supervisor is to:

- Oversee the practice you do.
- Build a working relationship with you.
- Attend supervision sessions which we organise punctually.
- Help you to identify work goals and the agenda that you bring to supervision.
- Offer appropriate challenge and give constructive feedback to help you improve practice.
- Assist you to acquire knowledge and skills to use in your practice.
- Support you in your personal and professional development.

I have given you the organisation's aims, objectives and policy on clinical supervision, which includes the guidelines on confidentiality and record keeping. I have read and agree to the organisation's policy on clinical supervision and am familiar with its general operation.

This contract can be reviewed at any time upon my request and it will be reviewed annually.

Name: **Date:**

Signature:

Based on: Cassedy, P (2010) *First Steps in Clinical Supervision; a Guide for Healthcare Professionals* pp.42-43. Open University Press.

An example of a contract/ground rules for group clinical supervision

The following is a list of ground rules is used as an illustration of what it is possible to include. The group itself should generate it's own list. The detail of each point is discussed within the group and agreed by all participants prior to the clinical supervision commencing.

Establishing ground rules in group supervision situations can help participants to feel safe to share their experiences and also help the group function healthily. It can be helpful to have the contract/ground rules on display during supervision sessions so that group members can stay mindful of what has been agreed.

- Confidentiality.
- Not to talk over each other.
- Respect for our colleagues and each other's opinions.
- Listen to each other.
- GSOH (good sense of humour).
- Challenge others respectfully.
- Awareness of others, try not to dominate the space.
- Keep to time.
- Allow people to own their own experience.
- Responsible for looking after ourselves.
- Remember that you can take time out should you need to.

Record keeping

Clinical supervision record

Attendees:

Print	Sign

Outline of issues discussed:

Signed:

Date:

Source: Helen & Douglas House (2014)

Individual record of participation in clinical supervision

All staff are required to provide evidence of participation in a minimum of 6 sessions of clinical supervision per year. Individuals will be required to keep a personal record of the clinical supervision that they participate in, and to present this record at their appraisal and interim reviews as required by their line manager.

It is anticipated that clinical supervision needs will be met through attendance at drop-in supervision groups. However, it is recognised that at times this may need to be either supplemented or supported by one of the other formats available within the [named organisation] menu of supervision.

Name:

Date	Type	Facilitator

Source: Helen & Douglas House (2014)

An example of a record keeping sheet for individual clinical supervision

This tool is a confidential document for the supervisee to use as an aide-mémoire for their supervision sessions. This record should preferably be kept by the supervisee. It is a [named organisation] requirement that supervision is recorded.

Supervision contract commenced:		
Supervisee:		
Supervisor:		
Date	Subjects raised	Points for next meeting (if applicable)
Review		

Source: Iain Rennie Hospice at Home (October 2010)

Resources for facilitators

Facilitator self assessment tool

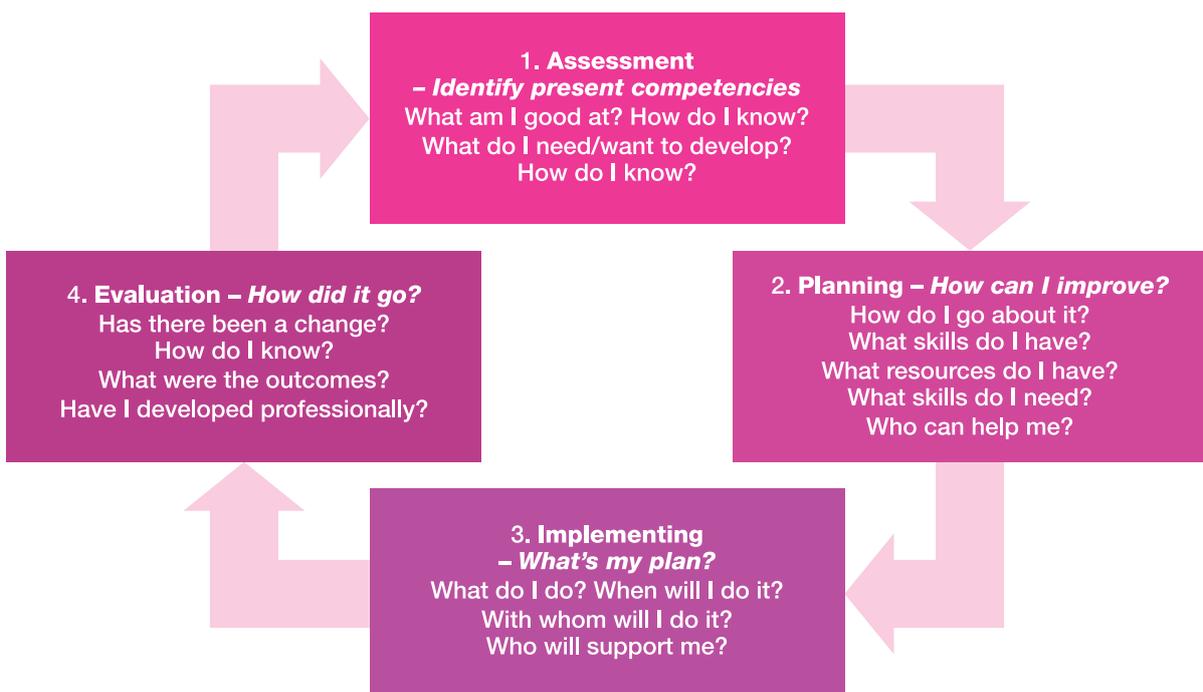
This self assessment tool is designed to help you reflect on your practice and development as a facilitator.

Self assessment, honestly reflecting on your facilitation skills, knowledge and qualities, supports your development as an effective facilitator. Continual reflection on your work as facilitator will help you to articulate and affirm the aspects of the role that you perform well, and to identify opportunities for ongoing development.

To use this self assessment tool:

- Consider each statement in turn, reflecting on your role as facilitator and the skills, qualities and knowledge that you bring to facilitation.
- For each statement, select a score between 1 and 4. A score of 1 indicates “*I am not feeling confident*” in relation to the statement, a score of 4 indicates “*I am feeling confident*”.
- When you have scored each statement, take some time to reflect on your scores. Affirm the things that you do well and your strengths. Consider where there might be opportunities to further develop your skills, and consider how you might want to take this forward.
- You may find it useful to use the reflective cycle below to support your thinking and planning.

Based on: Cassidy, P (2010) *First Steps in Clinical Supervision – A Guide for Healthcare Professionals*. Maidenhead: Open University Press



	Self assessment statement	Score			
		1	2	3	4
1	I can define what clinical supervision is				
2	I understand the aim and purpose of clinical supervision				
3	I am aware of my own facilitation style				
4	I understand the formative, restorative and normative functions of clinical supervision				
5	I can describe the various types of clinical supervision on the menu				
6	I am clear about what clinical supervision is not				
7	I am clear about the boundaries of clinical supervision				
8	I know what to discuss when contracting for clinical supervision				
9	I can apply the concepts of reflective practice				
10	I can demonstrate the following qualities (please score each one):				
	• Empathy				
	• Genuineness				
	• Respect				
	• Trustworthiness				
	• Sensitivity to the participants gender, age and ethnic background				
	• Sensitivity to the participants professional training, knowledge and experience				
	• Tact				
	• Curiosity				
	• Objectivity				
11	I can achieve a balance between the formative, normative and restorative functions of clinical supervision				
12	I can both give and receive constructive feedback				
13	I can use the skills of challenging appropriately				
14	I have strategies to employ for sessions where a participant(s) become upset				

	Self assessment statement	Score			
		1	2	3	4
15	I am willing to use a range of strategies to support learning and reflection e.g. exploration, imagination, role play, creativity etc.				
16	I can help participants to identify the impact of their own responses to the patient/situation they bring to supervision				
17	I can navigate the boundaries of the facilitator role				
18	I can develop the skill of reflective practice in participants				
19	I model appropriate ethical behaviour				
20	I accept and celebrate diversity				
21	Commitment to the role of facilitator				
22	Able to convey enthusiasm for clinical supervision				
23	I can demonstrate the following abilities in the role of facilitator (please score each one):				
	• Willing to negotiate				
	• Be flexible and adaptable as and when required				
	• Bring a sense of humour				
	• Recognise my own strengths				
	• Recognise opportunities for my own development				
	• Courage to expose vulnerabilities, make mistakes and take risks				
	• Commitment to attend and participate in my own supervision				
	• Commitment to updating knowledge and skills of clinical supervision				
	• Meet with other facilitators to exchange feedback and reflect on the role of supervisor				

Self and other assessment questionnaire for supervisors

This self-assessment questionnaire affords you the opportunity of getting some 360° feedback from supervisees, peers, tutor and supervisor. Each person is asked to rate each area of skill on a one to five scale. To create some common understanding of how to use this rating scale the following definitions are offered:

- 1 Professional learning need** – don't know how to do this.
- 2 Second Stage learning need** – know how to but unable to make it happen.
- 3 Sporadically competent** – occasionally do it fine.
- 4 Consistently competent** – this has become part of natural way of doing things.
- 5 Mastery** – can role model for this – can teach it to others.

<i>See above for full definition of headings</i>		1 Professional learning need	2 Second stage learning need	3 Sporadically competent	4 Consistently competent	5 Mastery
Knowledge						
1	Understand the purpose of supervision					
2	Clear about the boundaries of supervision					
3	Understand the following elements:					
	• Managerial/professional					
	• Educative/developmental					
	• Supportive/restorative					

<i>See page 111 for full definition of headings</i>		1 Professional learning need	2 Second stage learning need	3 Sporadically competent	4 Consistently competent	5 Mastery
C.L.E.A.R supervision skills C (contract) L (listen) E (explore) A (action) R (review)						
C1	Can explain to supervisees the purpose of supervision and can describe one's own way of working					
C2	Can negotiate a mutually agreed and clear contract (practicalities; roles and responsibilities; boundaries; joint-success criteria)					
C3	Can maintain appropriate boundaries					
C4	Can set a supervision climate that is:					
	• Empathic					
	• Genuine					
	• Congruent					
	• Trustworthy					
	• Immediate					
C5	Can maintain a balance between the managerial, educative and supportive functions					
C6	Can end a session on time and appropriately					
L1	Can listen well at multiple levels					
L2	Can appropriately match different people and build rapport quickly					
L3	Can use a range of appropriate questions					

<i>See page 111 for full definition of headings</i>		1 Professional learning need	2 Second stage learning need	3 Sporadically competent	4 Consistently competent	5 Mastery
E1	Can flag clearly the intent of an intervention					
E2	Can use the following types of intervention:					
	• Prescriptive					
	• Informative					
	• Confrontative					
	• Catalytic					
	• Cathartic					
	• Supportive					
E3	Can appropriately express a wide range of emotions					
E4	Can enable transformational moments in the here and now					
A1	Can move supervisee into action phase					
A2	Can clarify the who, what, when, where and how of the action					
A3	Can help supervisees to rehearse appropriate interventions					
R1	Can give feedback in a way that is:					
	• Clear					
	• Owned					
	• Regular					
	• Balanced					
	• Specific					

<i>See page 111 for full definition of headings</i>		1 Professional learning need	2 Second stage learning need	3 Sporadically competent	4 Consistently competent	5 Mastery
Process skills (M=Mode) Can skilfully focus on:						
M1	Client content/phenomena					
M2	Supervisee's interventions					
M3	Supervisee/client relationship					
M4	Supervisee's reactions and assumptions					
M5	Supervision relationship and parallel process					
M6	Own reactions and assumptions					
M7	The wider context					
Capacities or qualities						
1	Takes appropriate leadership					
2	Has the appropriate authority, presence and Impact for the role of supervisor					
3	Able to build relationship and comment on it					
4	Able to encourage, motivate and carry appropriate optimism and develop self-supervision skills in supervisee					
5	Has awareness of when they find themselves deferring to others					
6	Can work across difference, trans-culturally sensitive to individual differences					
7	Has developed and practices ethical maturity					
8	Has a sense of humour					
9	Has a sense of humility					

<i>See page 111 for full definition of headings</i>		1 Professional learning need	2 Second stage learning need	3 Sporadically competent	4 Consistently competent	5 Mastery
Commitment to one's own ongoing development						
1	Can ensure own appropriate supervision					
2	Committed to updating own practitioner and supervisory skills and knowledge					
3	Can recognise own limits and identify own strengths and weaknesses as a supervisor					
4	Receives regular feedback from					
	• Supervisees					
	• Peers					
	• Own supervisor/seniors					

<i>See page 111 for full definition of headings</i>		1 Professional learning need	2 Second stage learning need	3 Sporadically competent	4 Consistently competent	5 Mastery
<i>Optional:</i>						
For group supervisors						
1	Can ensure knowledge of group dynamics					
2	Can use the process of the group to aid the supervision process					
3	Can handle competitiveness in groups					
For senior organisational supervisors						
1	Can supervise inter-professional issues					
2	Can supervise inter-organisational issues					
3	Has knowledge of stages in team and organisational development and systems theory					
4	Can surface the underlying team or organisational culture					
5	Can facilitate organisation change					
6	Can create a learning culture in which supervision flourishes					

Please try and use an appropriately wide range of scoring, do not reduce everything to a median score. After scoring this yourself, please send copies of this self-assessment questionnaire to two supervisees, one colleague/peer and your supervisor. Arrange for feedback from each person who fills in one of these forms. The objective is not so much to arrive at a score, but to start a series of 360° conversations that will hopefully stimulate further learning and new areas of focus for the development of your practice.

Source: Centre for Supervision and Team Development Bath (1986) – see CSTD.org.uk

Supervisors checklist

- Did I enable the supervisee to describe their experience?
- Did I affirm and support the supervisee?
- Did I enable the supervisee to reflect on their experience?
- Did I share knowledge/information as appropriate?
- Did I listen more than I spoke?
- Did I use questions to enable the supervisee to describe, reflect and seek conclusions?
- Did I try to understand how the supervisee was feeling?
- Did I maintain the focus of the session?
- Did I maintain appropriate boundaries?
- Did I seek feedback from the supervisee?
- What do I need to take to my own supervision?

For further personal reflection, consider each question beginning with “How did I...?”

Adapted from: Driscoll, J. (2000) *Practising Clinical Supervision: A Reflective Approach*. Balliere Tindal

Clinical supervision assessment

The MCSS-26 tool, previously the *Manchester Supervision Scale* is a resource that has been developed to facilitate evaluation of clinical supervision provision within an organisation. It is completed by individual participants and has been shown to have some validity. A sample copy can be viewed at the web address below:

www.osmanconsulting.com/assets/docs/mcss_sample.pdf

The scale is copyrighted and hence only usable by organisation for a cost. To find out more visit the website below:

www.osmanconsulting.com

Clinical Supervision: Further Reading

Further Reading

The role and benefits of clinical supervision

Butterworth (1997) *It is Good to Talk: An Evaluation of Clinical Supervision and Mentorship in England and Scotland*. Manchester: University of Manchester

Girling, A (2009) How Clinical Supervision can Improve Hospice Care for Children. *Nursing Management*, 16 (7), pp20-23

Jones, A (1997) A 'Bonding Between Strangers': A Palliative Model of Clinical Supervision. *Journal of Advanced Nursing*, No.26, pp1028-1035

Jones, A (2008) Clinical Supervision can Benefit Palliative Care. *European Journal of Palliative Care* Vol.15, No.4, pp161

McVey, J and Jones, T (2008) Assessing the Value of Facilitated Reflective Practice Groups. *Cancer Nursing Practice*, 11 (8), pp32-7

SCIE (2012) *Research Brief: Effective Supervision in Social Work and Social Care*. Available at:
<http://www.scie.org.uk/publications/briefings/files/briefing43.pdf>

Trueland, J (2013) Breathe New Life into your Flagging Career. *Nursing Standard*, 27 (37), pp20-22

Walker, J (2009) Examining the Benefits of Professional Clinical Supervision. *Kai Tiaki Nursing*, 15 (5), pp12-14

Implementing clinical supervision

Bailey, E and Graham, M (2007) Introducing Guided Group Reflective Practice in an Irish Palliative Care Unit. *International Journal of Palliative Nursing*, Vol.13, No.11, pp555-560

Bryant, L (2010) Clinical Supervision. *Practice Nurse* Vol.39, No.12

Chilvers, R and Ramsey, S (2009) Implementing a Clinical Supervision Programme for Nurses in a Hospice Setting. *International Journal of Palliative Nursing* Vol.15, No.9, pp615-619

Gold, L and Dempsey, R *Clinical Supervision in the Reflective Learning Organisation*. Children's Hospices Across Scotland (CHAS). Available at:

http://chas.org.uk/assets/0000/8726/Clinical_Supervision_in_the_Reflective_Learning_Organisation.pdf [link now unavailable]

Jones, A (2006) Group-Format Clinical Supervision for Hospice Nurses. *European Journal of Cancer Care*. Vol.15, No.2, pp155-162

Jones, A (2006) What do we Know and What do we Need to Know? A Review and Commentary. *Journal of Nursing Management*. Vol.14, No.8, pp577-585

Lilley, L, David, M, and Hinson, P (2007) Implementing Inter-Professional Supervision within a Hospice Setting. *Cancer Nursing Practice* Vol.6, No.2, pp25-28

Rushton, D (2011) Developing In-House Clinical Supervision for all. *BMJ Supportive and Palliative Care* Vol.1, No.2, pp250-251

Watmore-Eve, J (2011) *Developing and Implementing a Model for Multi-Disciplinary Clinical Supervision*. Available at:
<http://www.helpthehospices.org.uk/our-services/education-training/past-events/conference-2011/posters/developing-and-implementing-a-model-for-multi-disciplinary-clinical-supervision-for-staff-within-a-hospice>

Guidance

Care Quality Commission (2013) *Supporting Information and Guidance: Supporting Effective Clinical Supervision*.

http://www.cqc.org.uk/sites/default/files/media/documents/20130625_800734_v1_00_supporting_information-effective_clinical_supervision_for_publication.pdf

Skills for Care (2007) *Providing Effective Supervision: A Workforce Development Tool, Including a Unit of Competence and Supporting Guidance*.

<http://www.skillsforcare.org.uk/publications/ProvidingEffectiveSupervision.aspx>



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