First Steps in Clinical Supervision
A guide for healthcare professionals
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Paul Cassedy

Open University Press
This book is dedicated to my Mum and Dad who always give me love, guidance and quality care.

Also to my sons and daughter, Daniel, Jackson, Phoebe and Jake, who give me continuous learning.

In loving memory of my brother, Martin, who was always there for me when needed.

Gratitude is not only the greatest of virtues, but the parent of all others.
—Cicero (106–43 BC)
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Chapter outcomes

By reading this chapter, doing the reflective activities, and integrating the material into your supervision practice, you should be able to:

- Acknowledge the difference between clinical supervision and similar roles already in practice.
- Understand a definition of clinical supervision.
- Know some background information to the emergence of clinical supervision.
- Acknowledge the difference between clinical supervision and therapy.
- Gain an overview of the functions of clinical supervision.
- Become aware of the main benefits of clinical supervision.
- Recognize and reflect on transferable skills which can assist becoming a supervisor.
- Recognize the importance of having guidelines for the introduction of clinical supervision.
- Recognize the importance and value of collaboration when implementing the guidelines of clinical supervision.
- Acknowledge the value of a training programme and know what to look for.
Introduction

Welcome to *First Steps in Clinical Supervision*. The words ‘clinical supervision’ are now known to the majority of people working in the helping professions but there still may be some misunderstanding of the concept. This first chapter offers a broad overview and introduction to clinical supervision, focusing on what I believe a beginning supervisor needs to know and understanding of. I hope it will also begin to clarify any misunderstandings you may have and raise issues and questions you may want to discuss. The chapter focuses on some of the important concepts, information and related issues that will be valuable to you as you take your first steps to becoming a clinical supervisor.

Becoming a clinical supervisor can be a rewarding yet challenging experience for the healthcare professional. I am assuming that, having picked up this book, you are in a position to take on the role of supervisor or are already in that role. You want to acquire more knowledge and skills and to further your understanding and development. You may need to remind yourself, as I still often do, of some of the pitfalls that we can slip into. You may need to revise existing skills or to have a look at and practise some new ones. Whatever your need, I hope you find something of interest here that will help you to reflect on your role and work as a supervisor. I hope you can go on to enjoy your role as supervisor and become good, and then great, at what you do: don’t just settle for being good enough. Aim high. Read more on the subject, develop more by continuing to reflect on your supervision practice, seek feedback from your supervisees and relevant others who are involved in the implementing process, and seek out further training and updates. Becoming proactive in this role will help you to lay the foundations upon which you can build towards your goals of increasing your potential and enabling quality practice as a supervisor.

Supervision is about working with people. Therefore you will be able to draw upon the many interpersonal and communication skills you use in your various roles in clinical practice. You may already have been involved in a role similar to that of a clinical supervisor, and, for some, this may be where a misunderstanding of the clinical supervisor’s role arises. I aim to address this in the next section.

Are similar roles already in place?

Several formal and informal professional roles are already in place that can serve some of the different functions of supervision. These roles will be fulfilled by such people as line managers, mentors, preceptors, tutors, consultant...
specialists and colleagues. Many other support systems are, however, time limited and have a specific focus and serve a specific need. For example, a newly qualified nurse is given a preceptor for 6 to 12 months, student nurses are allocated a mentor, staff support groups are arranged for debriefing sessions. Wilson (2000) purports that to distinguish between similar roles and clinical supervision can be a ‘thorny problem’ (p. 187) as at times those roles have been interchangeable and there is inconsistency among the terms used and their prescribed uses. He goes on to consider the differences to good effect and puts a strong case for the defined role of clinical supervision. Lynch et al. (2008) also comprehensively distinguish clinical supervision from other formal relationships and examine some common myths and misconceptions. Scaife (2009) explores how the term ‘clinical supervision’ has been used in the literature, detailing the features that characterize supervision and that help to distinguish it from similar activities.

If there is an answer to the question ‘are similar roles already in place?’, it is not an entirely obvious one, and therein lies the conundrum. However, my answer would be as follows:

Other, similar roles may serve some of the functions of clinical supervision some of the time, but not all of the functions of clinical supervision all of the time.

I believe that the role of the clinical supervisor is to merge aspects of the similar roles. But in doing so, the clinical supervisor is forming a distinct and formal regular relationship for the purpose of and aim of clinical supervision. Supervision is therefore designed for career lifelong enhancement of clinical practice, support and learning, for all healthcare staff. It becomes a unique and tailor-made relationship for the supervisee, where they feel safe and supported enough to reflect and learn while exploring their clinical practice to enhance patient and client care.

Reaching a definition

As clinical supervision began to emerge across the healthcare professions, Butterworth and Faugier (1992) acknowledged the difficulty in reaching a precise definition of the term. As the seeds of ideas have been planted, so numerous definitions of clinical supervision have seen the light of day in the increasing number of books and papers on the subject. These definitions reflect to some extent the scope of the term as there is a diversity of healthcare settings where it is being implemented and of practitioners to whom it is being applied.

As the supervision relationship is the vehicle for its success, a definition also
needs to reflect on the relationship between supervisor and supervisee. Faugier (1992) outlines this well. She proposes the essential characteristics and espouses the qualities of a supervision relationship. Definitions of supervision may differ across different healthcare settings and groups, but a review of the literature reveals three general areas for practice:

- Quality assurance and the provision of quality care and standards.
- A method of learning to develop and improve practice.
- Professional and personal support.

Brockelhurst (1994) identified common features in numerous definitions of clinical supervision which encompass the above, managerial, educational and supportive, elements:

- Supervision is an active process necessitating equal input from supervisor and supervisee.
- The process of supervision requires structures and procedures.
- Supervision has a number of related aims: ensuring safe practice, developing skills, encouraging personal and professional growth, and supporting staff.
- The supervision relationship is of fundamental importance.

Note the following definitions which incorporate those terms:

_A formal process of professional support and learning which enables individual 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._

(Department of Health 1993)

_As a working alliance between practitioners in which they aim to enhance clinical practice . . . [to] meet ethical, professional and best practice standards. While providing personal support and encouragement in relation to professional practice . . ._

(Kavanagh et al. 2002: 247)

It is interesting to note that the latter and more recent definition includes the term ‘working alliance’, to emphasize the importance and value of the supervision relationship. A review by Kilminster and Jolly (2000) concludes that ‘the quality of the supervision relationship is probably the single most important factor for the effectiveness of supervision’. Borders (2005) also identifies that the supervisor–supervisee relationship is critical to the overall process.

A working alliance can be defined in this context as a working partnership based on a mutual agreement to fulfil the expectations of clinical supervision. This, now often referred to as a supervisory alliance, will require of the supervisor such qualities as will enable them to establish a trusting and
empathic relationship. The skills to develop a safe and facilitative learning climate are also required.

In my definition that follows, and the one I shall be working with, I have importantly included the words ‘facilitation’ and ‘relationship’ to emphasize how the three main functions of support, learning and quality care can be enhanced.

Clinical supervision can be defined as a regular and formal agreement to engage in a professional working relationship, facilitated by the supervisor to support the supervisee to reflect on practice, with the aim of developing quality care, accountability, personal competence and learning.

Reflective activity

Drawing on your own understanding and experience of clinical supervision as they are now, ask yourself:

- What is important for you to include in a definition of clinical supervision?
- How do your fellow healthcare professionals define clinical supervision?
- Do you feel the definition and objectives of supervision are up for debate? If not why not?
- How are you going to define what clinical supervision is when asked by a colleague or a new supervisee?

Some background information

Clinical supervision began to appear in the 1920s in classical psychoanalysis. The concept developed and became integrated into the practice of professions using psychotherapeutic forms of treatment. Reference can be found in the literature of psychotherapy, counselling, psychology, psychiatry, social work and occupational therapy.

Hildegard Peplau (1909–1999) was influential in helping to give prominence to the practice of supervision in nursing. The subject has been appearing in literature for healthcare professionals in the United Kingdom since the 1980s, and in 1982 the Registered Mental Nurse syllabus flagged up the term ‘clinical supervision’. The Department of Health report A Vision for the Future (1993) included the following key target related specifically to clinical supervision:

The concept of clinical supervision should be further explored and developed. Discussion should be held at local and national level on the range and appropriateness of clinical supervision and a report made to the professionals.
Since that time the concept has been debated, recommended and advocated by healthcare academics, educationalists, managers and practitioners throughout the United Kingdom. During the 1990s, clinical supervision became better established and was recommended for practice across all the helping professions (Butterworth and Faugier 1992; Hawkins and Shohet 2000). The factors that created this drive derived from the many political, professional, educational and managerial changes that were taking place in healthcare delivery. Fowler (1996), Bond and Holland (1998) and Driscoll (2000) offer more detailed accounts of the emergence and developments of clinical supervision for healthcare practice.

This supervisor’s background

My own nursing background was in mental health. It was when I was a community psychiatric nurse that, as a team, we started a support group among ourselves which took on some of the elements of clinical supervision. I was at the time undertaking a counselling skills certificate, and supervision was a fundamental part to the training. I began to recognize the importance of support when in the role of helper, and learnt the values of exploring oneself in relation to client work and efficacy of practice. Further training in humanistic psychology brought me into contact with a variety of practitioners and trainers, all of whom I have learnt something from in the vast arena of therapeutic growth and development. I moved into nurse education, where I was able to pass on some of that experience and knowledge on the various interpersonal skills training courses that I was involved in.

I continued my counselling practice and was fortunate to receive both group and individual supervision from a variety of supervisors. Increasingly over the years I have reaped the benefits – and I believe my clients have too – of supervision, as I have developed personally and professionally and become more effective and therapeutic as a counsellor. Further studies in counselling practice enabled me to explore more academically the role and function of supervision while assimilating and synthesizing the theories and concepts.

I have subsequently been involved in various aspects of supervision for many years. I have been a supervisor to various healthcare staff before the practice became fully established within their organizations. I facilitate group supervision and, through attending training courses, workshops and conferences, I have helped develop and deliver training programmes for clinical supervision within my role as a tutor. I have also facilitated others to help implement supervision in their practice settings and I supervise supervisors.

Few, if any, of the materials, theories and frameworks in this book are new ideas or approaches in the arena of supervision, interpersonal skills and
personal development. I have merged some concepts and adapted them to a clinical supervision context. I have also integrated many of the skills and ideas that supervisors and educators have used with me in the past, utilizing and learning from the most helpful as well as the least helpful. They have been accumulated, tried and tested over time, and there is still ongoing development within my training and supervision practice. I adhere to a statement made by Shohet (1985), that we teach what we most need to learn. That phrase has lived with me over time, and as the years have passed I am still learning my trade. I only hope that, to rephrase a lesson from the Dalai Lama which is pertinent here, in my older years I can look back with some pride and a little honour on the work I have been involved in, so through those memories I might be able to enjoy those experiences a second time. If that hope is to come to fruition, I firmly believe that the supervision I have myself experienced will have been essential in enabling the work of which I am proud.

One reason that I introduced myself like this is that you, as a supervisor, will probably be called upon when starting your role to say something of yourself, your background and your experience—but probably not, I hope, all in one go as I have here.

The name of clinical supervision

From my experience of delivering training in supervision I am aware that the word ‘supervision’ conjures up a variety of thoughts and feelings. These thoughts have resulted from practitioners’ prior experiences and opinions, both positive and negative. Both confusion and cynicism have had a direct influence on levels of enthusiasm and interest in the subject. It has also been suggested that the term ‘clinical supervision’ is a rather unfavourable one. It can conjure up images of the superintendent on surveillance duty. The made up word of ‘snoopervision’ I have also heard voiced. Yet, if you look up the two words ‘clinical’ and ‘supervisor’ in the dictionary you will find a supervisor described as an ‘overseer’ and clinical as ‘observation of the patient’. I find the term perfectly adequate for the purpose and functions. ‘Reflective practice’ has been suggested as a more favourable term, but I feel this does not fully meet the functions and aims of clinical supervision.

Try dissecting the word so it becomes ‘super – vision’, as this perhaps highlights that it is not as prescriptive as it at first seems. The aim is to create a process where the supervisee can have access to and increase a super form of vision over their work and performance. For the purposes of this book, the term ‘supervision’ will be used when referring to what is generally agreed to be ‘clinical supervision’.
Reflective activity

- Reflect on the words ‘clinical supervision’.
- Be aware of your own experience in the past, when someone has been ‘overseeing’ you in relation to patient care.
- How have those experiences influenced your current conception of the term ‘clinical supervision’?
- Would you consider modifying the name? If so, what to?
- How are you going to describe and define the title of ‘clinical supervisor’?

Supervision as a journey

The metaphor of a journey has been used to describe the developmental process of supervision for both of the parties involved. I also subscribe to that notion, and supervision has for me been about exploration and discovery. As a supervisor, however, we must be clear that it is our supervisee’s journey that we are now working on and that this journey is to be continuous. I hope by reading this book you may find, explore and discover ideas, techniques and thoughts that will assist you with the task and opportunity in front of you. It is a privilege to be a supervisor as you are entering into a unique learning journey with your supervisee. It is an opportunity to build a relationship on trust and honesty and one that embodies professional and personal development for the overall aim of enhancing healthcare practice.

Is supervision therapy?

If supervision is a journey and a developmental process, it is necessary to clarify the boundary between supportive supervision and therapy, as this can be problematic. You will need to ask yourself where the boundary between supervision and counselling lies. This question can surface when the supervisee is under stress as a result of the often emotionally draining and challenging work they are carrying out. You will need to consider, for example, if the source of stress is current personal or professional relationships and issues, or whether it is more personal to the supervisee and more deeply rooted in their past. These deeply rooted problems, that still surface, are often referred to in therapy as ‘family of origin’ experiences and certainly would not be an area to focus on. Whatever the causes of current stress and strain, you will need to
ask yourself why you might need to pursue them and whether this should be focused on in supervision.

To begin to address the question of ‘is supervision therapy?’, I agree with Bernard and Goodyear (1998: 7) who recommend that ‘any therapeutic intervention with supervisees . . . should only be in the service of helping supervisees become more effective with clients’. They go on to state that providing therapy that has more comprehensive intentions is ethical misconduct. Scaife (2001) also notes there is a clear distinction between therapy and supervision in terms of the former being learning for life, and the latter learning for work.

There are inevitably some similarities between supervision and counselling. Skills of active listening and qualities of developing a working alliance are common to both. The environment and arrangements may also be similar. Regular sessions are arranged by formal mutual agreement, and the sessions take place in private. As a supervisor you need to be aware of these similarities, as the supervisees may at first have apprehensions and anxieties that perhaps supervision is counselling. You need to be clear of your role, not just in being able to define it but also in being able to distinguish it from counselling. You need to be able to discuss and explore the parameters and be clear in your own mind where the boundaries are and when you are straying from the task of supervision. Scaife (2009: 17) suggests that it is always useful for the supervisor to have in mind the question ‘how is it relevant to the work?’ as a means of preserving the boundary between supervision and therapy. However, your counselling skills can be utilized as and when appropriate during sessions. You may want to think of it as work therapy when you are using counselling skills for supportive intentions. Always have in mind, though, that your therapeutic interventions are for the benefit, first and foremost, of the supervisee’s performance and ability to practise effectively in their work setting and organization. Consider, for example, a situation in which your supervisee has recently suffered the loss of a parent due to a recurring illness. They have returned to work but do not feel quite ‘back on their feet again’, and they still have mixed or unfamiliar emotions that are at times affecting their concentration. You need to be supportive and to utilize counselling skills in enabling the supervisee to regain personal and professional ability and personal confidence. But what if that parent had an unexpected or tragic death and has left your supervisee in shock, and they have returned to work to try to get on with things and cope? You need to ask yourself whether you are competent and skilled enough to help support them through their recent trauma and whether supervision is the appropriate place for this. You need also to recognize, as they may not be aware of this themself, that they would benefit from further and more specialist expertise.

To summarize, here are some important points to consider:

- Clinical supervision is not personal counselling or therapy.
- Counselling skills can be utilized in supervision to provide support with the focus clearly on the supervisee’s performance, ability and effectiveness in their work setting.
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- As a supervisor, I have the necessary skills, knowledge and confidence to provide this support.
- As a supervisor, I have the awareness to suggest to the supervisee that perhaps they might seek more professional help and experience.
- As a supervisor, I am able to recognize and advise the supervisee that they do require further professional help.
- As a supervisor, I am aware of the resources and services available to the supervisee for any further professional help and support.

Categorizing clinical supervision into functions

The concept of clinical supervision accommodates a wide berth within a wide range of helping organizations. There also is a vast amount of literature that examines the many contexts that clinical supervision serves. Nevertheless, even within those different environments, supervision follows and endorses similar aims and objectives as well as guidelines and principles. Funnelling the various aims and functions into a coherent structure that became workable for healthcare professionals was a task to be achieved. It was from Kadushin’s (1992) original framework that Proctor (1986) put forward a categorization of supervision that would help identify the functions and components of clinical supervision in healthcare settings today.

Proctor’s (1986) three categories are:

- Normative (managerial)
- Formative (learning/educational)
- Restorative (supportive)

I have identified in brackets the functions that the category serves, but if you have not done so already, familiarize yourself with the terms ‘normative’, ‘formative’ and ‘restorative’. They can be referred to as both categories and functions.

Many authors, for example Bond and Holland (1998), Power (1999) and Driscoll (2000), refer to the three categories as main functions of clinical supervision and advocate them as a framework for the supervisor and organizations to adopt. Many organizational policy statements on clinical supervision in the United Kingdom now cite these three functions in the context of a framework as a focus to meet aims and objectives of supervision. I strongly support those views, as this framework is particularly suited to healthcare settings as it focuses on tasks and roles (Inskipp and Proctor 1993).

As well as being a conceptual framework for the aims and objectives of supervision, the normative, formative and restorative categories can also help to identify a focus for the following:
The qualities, skills and knowledge of a clinical supervisor.
A training programme for clinical supervisors.
The anticipated benefits of clinical supervision.
A focus for evaluation and research.

Let us now take a brief look at the normative, formative and restorative categories and the key functions they serve for clinical supervision.

**A managerial category – normative**

- This function of clinical supervision is concerned with maintaining and developing standards of safe, ethical and quality practice.
- The focus is on enhancing the effectiveness and ability of the supervisee’s clinical role and performance for and within the organization.

As a clinical supervisor you are helping the supervisee to examine and reflect on the work they do and explore ways of maintaining and improving quality and efficiency for the good and care of the patient. Supervision provides an opportunity to reflect on complex cases and issues. Individual thoughts and feelings regarding approaches to treatment, care, evaluation and planning can be reflected upon in clinical discussions that take place within the clinical environment. Such discussions provide an opportunity to demonstrate accountability and responsibility in the continuous improvement for practice (UKCC 1996; NMC 2005a). The normative category is in place also to ensure national and clinical guidelines are adhered to and the supervisee is working to those objectives.

Clinical supervision, however, is not line management: for example there is no role for formal appraisal of performance, and you are not in this role as the supervisee’s manager. However, as supervisor you are often wearing a managerial hat regarding the above issues, as you may need to raise matters of concern, and respond and make any decisions with the supervisee as appropriate. Ideally, a clinical supervisor will not be the supervisee’s line manager as this may result in a conflict and confusion of roles. A line manager will also have certain administrative duties that they need to fulfil which may preclude a supervision relationship with a member of their own staff. This, however, does not mean that a line manager is unable to be a clinical supervisor. If they have the skills and self-awareness to be a clinical supervisor it may not be their title that is the issue so much as their other roles and responsibilities in relation to their supervisee.

**A learning and educative category – formative**

- This function of clinical supervision is to help you to reflect with confidence on your professional role, knowledge and skills as an individual and within a multidisciplinary team.
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• The focus is to enable you to learn and develop professional skills by receiving feedback and to develop new ideas.

This category assists the supervisee to become aware of strengths and weaknesses in their work. By developing insight through reflective practice and becoming more knowledgeable, the supervisee can relate theory to practice and integrate this learning in their clinical practice. This may lead to identification of specific training and development needs. However, as a supervisor you must remember that you are not the supervisee’s tutor or teacher, although at times you may be wearing those hats.

A supportive category – restorative

• This function of clinical supervision is concerned with how the supervisee responds emotionally to the stresses of working in a helping environment and caring for others, while allowing time for self-appraisal and well-being.
• The focus is on building a nurturing supportive relationship that can help reduce stress while providing motivation and encouragement.

Helping your supervisee express feelings and concerns as an individual in their work can also help in developing insights into and new perspectives on ways to manage. Hawkins and Shohet (2000) refer to this category as ‘pit head time’: ‘The right to wash off the grime of the work in the boss’s time, rather than take it home’ (p. 51).

This protected and planned time is also a time to balance up the positive aspects by encouragement, praise and constructive feedback. However, remember that while in this role you are not the supervisee’s counsellor, although you will be utilizing counselling skills as and when appropriate.

The many factors and issues that arise in each of the three categories are integrated and feed into each other. To develop the skills of being a clinical supervisor, therefore, will require flexibility, creativity and knowledge of individual supervisees’ needs and experience. The normative, formative and restorative functions are explored in more depth in Chapter 4, where consideration is given to the skills needed for the supervisor.

Reflective activity

Consider and reflect on the normative, formative and restorative functions that have been described.

• Has your experience of clinical supervision included elements of each of the functions?
• If not, why not? (This could be because you receive different types of supervision, e.g. caseload and managerial supervision from your manager.)
Do you feel there are any objectives of supervision that would not have a place within those three categories? What would be your case for that objective? Would other supervisors agree with you?

Benefits of clinical supervision

Before we move on to explore some of your reasons for becoming a supervisor, I will make a list of the possible benefits that clinical supervision can have. Research-based evidence is still rather thin on the ground, and Cutcliffe (2001) argues that to link improved patient care with received clinical supervision is extremely problematic to orchestrate. If clinical supervision is to be firmly established in this millennium and sustained, there is a need for more rigorous research, in particular studies on the effectiveness of clinical supervision with patient or client outcomes. Rafferty et al. (2007: 233) poignantly point out that ‘this remains the Holy Grail for clinical supervision research’. The benefits to nurses of clinical supervision are, however, evident in several studies, and there is an overwhelming positive response (Butterworth et al. 1997). Some of the positive outcomes demonstrated by these studies are:

- Improved worker retention (Harvey and Schramski 1984).
- Improved communication among workers (Webb 1997).
- Increased job satisfaction (Butterworth et al. 1997; Milne and Westerman 2001).
- Support for supervisees in a regular and formal arrangement to discuss clinical practice (Teasdale et al. 2001).

The following set of outcomes can be described as anticipated benefits of good quality clinical supervision. I have grouped them under the headings of normative, formative and restorative and whom they could possibly benefit.

Normative function: benefiting the organization

- Safeguards standards of patient care by promoting best practice.
- Promotes self-awareness of professional accountability.
- Committed staff because they work in a culture where learning and development are valued.
- A culture in which work is valued and patients are valued.
- Staff have the opportunity to be proactive as the organization is more flexible and creative.
• Encourages patient-focused care as planning and care options are reflected on.
• Provides a sounding board for decision making.
• Reduction in sickness rates.
• More likely to retain and recruit staff.

Formative function: benefiting the supervisee
• Learning opportunities for both supervisee and supervisor.
• Promotes integration of learning and practice.
• Encourages and supports lifelong learning.
• Encourages reflective practice on performance, efficacy and development of analytical skills.
• Increased self-awareness on aspects of work-related personal and professional responsibilities and abilities.
• Helps to identify further training and educational needs for personal and professional development.

Restorative function: benefiting the supervisee
• Support for emotional release.
• Validation and affirmation of ideas, views and feelings.
• Challenge and feedback on current thinking leading to new understanding and development.
• Increased motivation.
• Increased creativity.
• Increased staff support and morale.

Benefiting the patient
• All of the above.
• Empathic nursing care.
• Motivated nursing care.
• Ethical-based nursing care.

Most, if not all, of the above would integrate and correlate with each other. I need to emphasize again that the above are only what can be described as the possible or anticipated outcomes and benefits. I have based this on the supervision literature I have read, also on my observations and understandings by listening, and on discussions in my practice and teaching of clinical supervision. I have suggested in Chapter 9 that some of the above would be possible to consider when it comes to evaluating supervision, for example themes and key areas that the supervisee brings to supervision and the perceived outcomes. For those of you who want to further investigate research methods that have been developed for clinical supervision, I suggest Gilmore (2001) and Winstanley (2001).
What are the reasons for becoming a supervisor?

Fitzgerald (2000) and Faugier (1992) are among many writers who have detailed some of the attributes and skills you need to become a supervisor. Some of these qualities you may already have in your locker and they will help and enable you on your journey. When considering reasons for becoming a supervisor I will again use the headings from the three categories of clinical supervision that describe its aims and purposes. I have adapted from Driscoll (2000) the following transferable skills as they are good indicators of what may possibly help and be needed for the role. I suggest you consider the following reasons and skills as you take your first steps towards becoming a clinical supervisor. Your confidence should benefit if you have experience of or are involved in some of the activities and situations mentioned.

Managerial reasons for becoming a supervisor (normative)

- You have asked to be a clinical supervisor following the various initiatives and policies that are now being implemented in your place of work.
- You have taken the initiative yourself.
- You are a firm believer in clinical supervision.
- You want to transfer existing skills you have in similar roles, into a more formal and defined role of clinical supervisor.

Examples of skills that would transfer into the normative role

- Being knowledgeable about organizational guidelines and policies relating to patient safety and codes of conduct.
- You have some knowledge and understanding of ethical standards that underpin your professional work.
- You have handled complaints with diplomacy.
- You participate in multidisciplinary team meetings and liaise with other healthcare professionals.
- You have completed objectives set at your last appraisal or personal review.
- You have had experience of managing within your clinical area and team.
- You have been called upon to express your professional opinion from senior colleagues.
- You have at times challenged more senior colleagues when standards and quality of care have been an issue.
- You are knowledgeable regarding the NMC professional code of conduct (2008) and related statutory issues, for example those regarding confidentially in clinical supervision.
- You are comfortable in the role of authority.
- You have experience of your own clinical supervision.
Reflective activity
- Make a note of which of the above skills and abilities you may need to experience or enhance.
- What other activities or roles would it be possible for you to adopt?
- Add any additional transferable skills that you have.
- How comfortable are you with the perceived position of authority and the actual responsibility that you have as supervisor?

Power and authority
When you occupy the position of supervisor you may be perceived to be in a powerful and authoritative role. This power may also be derived from being an expert in your field. This, however, should not be an encouragement to fall into the trap of seeing the supervisee as powerless. Whenever possible and plausible, involve the supervisee in the important decision making and problem solving. Such interventions also promote relationship building and working together. This might be achieved by saying something along the lines of, ‘I am wondering what you think would be the best way to take this forward?’ or, ‘Would it be okay if I paused for a moment there? You are asking many significant questions and it’s important for you that we come up with some suitable ideas. What are your first thoughts?’

There may very well be issues on which you do need to exert your authority. Among these will be when you need to refer to the supervision contract, issues regarding the professional code of conduct and other issues of concern regarding your supervisee. These are considered and explored more in Chapter 2.

Learning reasons for becoming a supervisor (formative)
- To further develop your knowledge and skills in the area of clinical practice.
- To further your skills and development as a trainer and educator.
- To become more creative in your role.

Examples of skills that would transfer into the formative role
- You have experience of working as a preceptor.
- You have experience of teaching junior members of staff.
- You subscribe to a relevant practice journal.
- You worked as part of a team and contributed to a relevant research project.
- You have attended study days or training in clinical supervision.
- You have experience of your own clinical supervision.
Reflective activity

- Make a note of which of the above skills and abilities you may need to experience or enhance.
- What other activities or roles would it be possible for you to adopt?
- Add any additional transferable skills and abilities that you have.

Supportive reasons for becoming a clinical supervisor (restorative)

- You are able to recognize and acknowledge that you are a good listener.
- Others tend to come to you to talk and open up more about themselves regarding patient care, work issues, or just to offload in general.
- You are able to recognize when something is bothering you and are able to confide in someone you trust.

Examples of skills that would transfer into the restorative role

- You demonstrate when appropriate the need for teamworking and bonding.
- Feedback from student evaluations cites your supportive and welcoming approach.
- You have experience of being a member of a support group.
- You have experience of being a patient’s advocate.
- You have experience of your own clinical supervision.

Reflective activity

- Make a note of which of the above skills and abilities you may need to experience or enhance.
- What other activities or roles would it be possible for you to adopt?
- Add any additional transferable skills and abilities that you have.
- In what situations in your work role do you feel helpless?
- Who will support you?

In the past, most supervisors in healthcare settings would have been placed in that position because of their experience with clinical skills and because their current position of responsibility enabled them to take on the role (Campbell 2006). However, becoming a supervisor and to be effective in the role demands additional knowledge, skills and abilities. It is also a responsible and senior position, and you need to be sure you are comfortable with the role. It is important that you have not been pressured or forced into this role as you
may then struggle with the level of commitment that is going to be needed. As
a clinical supervisor you also need experience of clinical supervision. Kohner
(1994) and Rolfe et al. (2001) state not only that the supervisor should have
training but also that they should be in a supervision relationship on their
own behalf.
You need to be genuine and honest with yourself in taking on the role of
clinical supervisor, as believing in your own abilities will help you become
more competent and effective. You may wish to consider the following ques-
tions as you begin to take on the challenge of becoming a supervisor.

Reflective activity
- What experience of clinical supervision would you least expect from your
  own supervisor?
- What competences do you have to start supervising?
- What would your colleagues, past and present, say your strengths are in this
  role?
- What would they say are areas for you to develop?
- How can you acquire any more experience that you still feel you need?
- What initiatives can you put in place to remain competent?
- Do you feel that you are a genuine role model to your supervisee?

For several years now clinical supervision has been emerging in the health-
care professions, and various recommendations for its introduction and
implementation in the workplace have been put forward (Kohner 1994). The
means to deliver and implement clinical supervision in the workplace can, and
will, be diverse. For example, arranging protected time for supervision sessions
to take place in a busy ward environment will require a different system from
that used by supervisors who work in the community and organize their
own caseload. There are vast numbers of published articles and a number of
books that examine, consider the recommendations and detail the implemen-
tation process, with all the issues, dynamics, agendas that will arise. For the
healthcare professions, Bond and Holland (1998) do this comprehensively,
as does Driscoll (2000). I do not wish to expand on this here as it will vary
across organizations and you may not be involved in the process. However,
it is important for you to acknowledge and have awareness of guidelines for
the introduction of clinical supervision, as, after all, that is what you will be
doing.
In 1994 the King’s Fund Centre published a report that offers guidelines
for the introduction of supervision (see box). These guidelines were derived
from practice and are still relevant as a general framework. In particular, they
highlight some of the issues that need to be discussed with managers and
educators.
Guidelines for the introduction of clinical supervision

1. Before introducing clinical supervision, its purpose should be discussed and clearly defined. This definition should be informed by a theoretical understanding of the role and function of supervision and equally by a practical understanding of the circumstances and needs of the unit and its staff.

2. All staff should be involved in the process of planning and introducing a system of clinical supervision.

3. Careful consideration should be given to the qualifications, skills and experience required of supervisors, and to their ability to meet the individual needs of supervisees.

4. All supervisors should be given opportunities to receive training and learn the skills that are needed to provide supervision that is both constructive and supportive. Those who receive supervision should have similar opportunities to learn about their role as supervisees.

5. All supervisors should also receive supervision, in order to monitor and develop the quality of supervision they provide.

6. Supervision should be available to all practitioners, regardless of seniority.

7. The content of supervision should be carefully defined, with boundaries agreed about what is and is not to be dealt with in supervision time. The processes to be used should also be made clear.

8. The relationship between supervisor and supervisee should be formally constituted. Ground rules should be negotiated and agreed.

9. It is essential that clinical supervision is monitored and evaluated. Supervisees and supervisors should play an equal part in these procedures.

10. Individual units need the support of their employing authority to implement and maintain a system of clinical supervision.

Source: King’s Fund Centre 1994

Relevant collaboration with others

From the above guidelines it is clear that there needs to be collaboration with other parties and that commitment and training are necessary. Motivation and dedication will be needed, but you will be unable to sustain these on your own and to stay effective without the ongoing support of relevant other parties. To continue with the theme of clinical supervision as a learning journey, you may want to ask yourself: Do I want to be secure in the middle of the boat or do I take up the challenges of holding on to the sides on my own? Beginning
supervision often feels as though you are testing the waters and getting your feet wet and, of course, that is (figuratively speaking) what you have to do. It will, however, be helpful not only to have the support of other significant parties, but also to continually keep them on board, in view and involved with the supervision process. So, who are the relevant other parties? One way to conceptualize this can be seen in Figure 1.1.

![Triangle for supervision implementation](image)

**FIGURE 1.1** Triangle for supervision implementation. (Adapted from Hughes and Pengelly 1997)

Figure 1.1 shows the desired situation between you the clinical supervisor, your employer or manager and your education provider. These should be the significant parties involved in collaboration to ensure the quality and effectiveness of the clinical supervision that has been, or is going to be, implemented. As Figure 1.1 indicates, there needs to be clear and open collaboration between the three parties. I have found that this triangle is helpful to conceptualize the roles and the dynamics of the main players in establishing clinical supervision in the healthcare setting.

Each significant party needs to see and be in contact with the others, and all need to be within equal reach. Working partnerships will need to be developed and maintained if supervision is to be ongoing. Ask yourself who are you going to turn to and ask for support and guidance when problems or issues arise.

If the implementation process has been thoroughly researched and explored, and the arrangements are in place, then you are ready to take your first steps in supervision. Implementation may be on a large scale, where many other disciplines have been involved and firm foundations are in place, or on a much smaller, individual scale. However, training and education should have been undertaken to develop the skills, principles and roles needed in supervision. Providing clinical supervision is a responsibility and should not take
place without sufficient and suitable training. I am highlighting this here to acknowledge the responsibilities that other parties have in your ongoing development as a supervisor. There is a need to monitor the process and the systems needed for successful and sustained delivery.

It is generally agreed that good employers look after their staff. In the pressured environment of healthcare, all healthcare staff should have the right to access clinical supervision, and the supervisor the right to be fully supported by those around them. As a supervisor, you will have responsibility for maintaining the supervision process within the organizational system in addition to the pressures of your workload. It is therefore vital that you have the full backing of your employer and manager. As the supervision sessions will be taking place during working hours, you will also need the support of colleagues to enable you to fulfil the role. To ensure, then, that your first steps into clinical supervision are effective, it is envisaged that a protocol has been formulated and agreed by the relevant parties. A suggested protocol for the desired situation would be as follows:

- The introduction and implementation of clinical supervision has resulted from detailed preparation and negotiation.
- There are clear contracts and expectations on all sides.
- All role definitions are clear.
- The aims and objectives of clinical supervision are agreed.
- Adequate training is provided.
- There is provision for supervisors’ own clinical supervision.

**Training for clinical supervision**

Often, supervisors have learnt their skills and techniques from their own supervisors, and this is a valid and important way of learning. Former supervisors are often excellent and competent role models; however, the opposite can also be true. The standards and practice of supervision being offered may have been less than desirable in meeting the needs of the supervisee or the organization. This may well influence how the new supervisor operates and their understanding of the role. Clinical supervisors need to develop their own style and not attempt to emulate the style of others. Learn from your own experience alongside developing new knowledge, understandings and experiences that a competent training programme can offer.

What constitutes a competent training programme? At the time of writing there are no clear guidelines or recommendations of a suitable length of course or content. Inevitably, the length of programmes will be variable, but it should be intended to suit the particular needs and context of the organization. The content needs to be designed and delivered by the relevant parties who are
committed to clinical supervision and have collaborated to produce a competent programme. I list below some questions to raise with your service and education providers regarding the training that is or will be on offer:

- What is the length of the programme and how has that been determined? If it is minimal, for example less than four days, then ask how is that justified and whether there are to be further updates and workshops.
- What content does it cover?
- Will the training prepare me adequately to become a clinical supervisor, and how will this be assessed and monitored?
- Is the training and experience going to be largely experiential? (This would more realistically convey and suit the material to be offered.)
- Will there be plenty of opportunity to give and receive constructive feedback with other participants and the programme leaders?
- What training is being offered to the supervisee? For example, is there to be awareness-raising sessions on the purpose of supervision, reflective practice and training on how to use clinical supervision to full benefit.

While talking to other relevant parties, listen out for their enthusiasm, dedication and rationale towards clinical supervision. This may begin to tell you something about their overall commitment or whether they are merely doing this as part of their role requirement and job description.

**Reflective activity**

Focus and look back on the training programme you have undertaken and ask yourself:

- What did you value the most?
- What did you value the least?
- From the programme content, what would you have liked more of? Less of?
- Overall, did the programme fulfil its objectives? If not, why not?
- Would you at some point in the future contribute to a supervision training programme?

**Conclusion**

This chapter has introduced clinical supervision, focusing on important issues and understandings that a beginning supervisor needs to be aware of and have in place before commencement. The next chapter focuses on the first meeting and making a supervision contract.
Key learning points

- In being able to define clinical supervision you are also able to distinguish it from other, similar activities.
- It is important to understand the antecedents of clinical supervision as well as emerging factors that commend its implementation in practice.
- As a healthcare professional you will have many transferable skills to use in the role of supervisor. However, you need first to understand the specific aims and objectives of supervision.
- Understanding the main functions of clinical supervision will help keep you focused on its aims and objectives.
- As a new supervisor, you have understanding of the importance and value of collaboration with the significant other parties involved to provide you with support and training.