This is the first (unedited) article which outlines some baseline skills in getting the most from clinical supervision sessions.

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GETTING THE MOST FROM CLINICAL SUPERVISION (1): THE SUPERVISEE

AIMS AND INTENDED LEARNING OUTCOMES

This the first of two articles, outlines some of the baseline skills of the clinical supervisee to maximise the time spent during clinical supervision sessions. It assumes no previous knowledge and is aimed predominantly at practitioners's considering engaging in one to one clinical supervision for the first time. After reading this article you should be able to:

- Be more conversant with what clinical supervision aims to achieve in practice
- Recognise whether clinical supervision is already happening in practice
- Identify some of the potential benefits of engaging in clinical supervision as a supervisee for your own practice
- Reflect on what skills you already use in clinical practice that are transferable into a clinical supervision session
- Assess your potential or current supervisory performance against the six baseline skills of a clinical supervisee
- Based on your personal reflections plan how as a supervisee you can more actively contribute to your future clinical supervision session

INTRODUCTION

The UK nursing literature on clinical supervision is rapidly expanding (Bishop 1998, Bond & Holland 1998, Butterworth & Faugier 1992, Butterworth et.al. 1997, Butterworth et.al. 1998, Dolley et.al. 1998, Fowler 1996, Fowler 1998, Kohner 1994), and is generally recognised by the nursing leadership as essential for registered nurses to develop clinical competence and to assume responsibility for their own practice (Department of Health 1993,1994, Kershaw 1995, RCN 1998, UKCC 1998, 1997, 1996). Despite this, many nurses seem to be struggling with what clinical supervision is and how it can affect their practice (Wright et.al. 1997).

Whilst qualified nurses are familiar with supervising the practice of student nurses and enter the relationship, with a degree of confidence about what they are expected to do,

the same cannot be said for qualified nurses entering into clinical supervision (Fowler 1996). Veronica Bishop (1998) in her definition, begins to identify the 'how' as well as the 'why' of clinical supervision;

Clinical supervision is a designated interaction between two or more practitioners within a safe / supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient services.

Though a relatively new concept to nursing generally, supervision has been an established part of practice in related disciplines such as counselling, psychotherapy and social work (Butterworth et.al. 1998, Playle & Mullarkey 1998). Not surprisingly much of the literature dealing with the principles and practice of supervision emerge from these areas (Brown & Bourne 1996, Hawkins & Shohet 1990, Hughes & Morcom 1996, Kadushin 1992, Pritchard 1995, Proctor 1986).

There is still not yet any consensus about definitions, principles and practice of mental health nursing supervision (Simms 1993), although the influence of supervision in counselling and psychotherapy is becoming more established in mental health nursing practice (Farrington 1995). It is unlikely that one clinical supervision model will suit all mental health nurses (Kipping 1998), but there would appear general roles and responsibilities for both the clinical supervisor and the supervisee.

The healing nature of counselling or psychotherapy differs from clinical supervision, in that the supervisee does not intentionally have as its prime focus the promotion of healing, although it must be acknowledged that some healing may take place (Deery & Corby 1996). There is an important distinction between the expectations of a client in a therapy situation and the supervisee in clinical supervision. The former has therapeutic expectations of the counsellor,whilst the latter requires guidance, support and the opportunity to reflect on their practice with another experienced professional (Fowler 1998).

Gadd & Mahood (1995) when developing clinical supervision in a mental health NHS Trust, noted that an advantage was that it was seen as a relatively inexpensive way of developing nurses, who at that time had very few ways and means of improving their practice, working as they did in an undervalued and underfunded service

NOW DO TIME OUT 1

View the RCN (1998) Nursing Update video *Caring together: clinical supervision*. You should be able to obtain a copy from your local nursing library, the RCN or postgraduate library. Write brief notes on some of the differences and similiarities between what is happening in your own daily practice and clinical supervision. Would you consider yourself to already be a clinical supervisee in your practice environment?

The whole success of clinical supervision ultimately rests with the willingness and commitment of clinical supervisee's to engage in it and learn from the experience (Bond & Holland 1998). But this has to be supported initially by the organisation. Some of the benefits to the clinical practitioner in engaging in regular clinical supervision may not be immediately obvious if they feel that to be effective in delivering care is to be giving to somebody, or something, rather than taking something for themselves during worktime. Clinical supervision is therefore a gift of time to the supervisee, from the organisation, in order to enhance personal and professional development that ultimately affects the quality of care given in clinical practice (Fowler 1998).

THE FUNCTIONS OF CLINICAL SUPERVISION

There appears to be some consensus in nursing following a national Clinical Supervision Evaluation Project (Butterworth et.al. 1997) that Brigid Proctor's (1986) Interactive Model of Clinical Supervision is a useful one to consider in practice. She describes the three key elements of clinical supervision that whilst relating to the role and function of the clinical supervisor, offers at least three different ways of viewing clinical practice (Box 1). Some authors (Rafferty et.al 1998), have adapted the three elements to make the terminology easier to understand and is illustrated in Box 1.

BOX 1
PROCTOR'S (1986) INTERACTIVE MODEL OF SUPERVISION THAT OFFER AT LEAST THREE DIFFERENT WAYS OF VIEWING CLINICAL PRACTICE.

FORMATIVE OR **LEARNING*** FUNCTION

concerned with the continued development of skills, abilities and understandings of the practitioner

RESTORATIVE OR **SUPPORT*** FUNCTION

concerned with how practitioners respond emotionally and survive the stresses of nursing work

CLINICAL SUPERVISION

NORMATIVE OR **ACCOUNTABILITY*** FUNCTION

concerned with maintaining and monitoring the effectiveness of nursing work

* Rafferty et.al. (1998)

The model of supervision may be likened to different models of nursing. In reality, the component parts merely represent the nurse theorists preference or focus for delivering patient care e.g psychosocial, physiological or rehabilitative etc. so there may also be preferences in the clinical supervision encounter. Although in the model of clinical supervision (Box 1) three elements seem to apply equally, in reality just like different nursing theories there will inevitably be unequal as well as overlapping foci by the clinical supervisor in the supervision encounter (Box 2).

NOW DO TIME OUT 2

Imagine that someone had secretly observed your behaviour on your last shift in clinical practice. How might they rate you in percentage terms of your LEARNING, SUPPORT AND ACCOUNTABILITY functions as a practitioner during the shift? (BOX 1).

If the secret observer had been your clinical supervisor, in what foci might you expect them to base giving you feedback about your last shift based on Proctor's model (BOX 2)?

It may now be possible to consider the different functions of supervision and how much one of the functions is avoided or overused by yourself in clinical practice, or conversely by your clinical supervisor in clinical supervision. A not uncommon question for you to consider might be whether when you go for supervision you are in clinical supervision or managerial supervision. Other authors have differentiated the differences elsewhere (Bond & Holland 1998, Burrow 1995, Driscoll 1996).

BOX 2:
OVERLAPPING OR EQUAL FUNCTIONS IN CLINICAL SUPERVISION TOWARDS THE SUPERVISEE BY THE CLINICAL SUPERVISOR?

FORMATIVE OR **LEARNING** SUPERVISORY FOCUS

facilitating the supervisee's professional development

RESTORATIVE OR **SUPPORT** SUPERVISORY FOCUS

focussing on how the supervisee is coping with the psychosocial demands of nursing work

THE SUPERVISEE IN CLINICAL SUPERVISION

NORMATIVE OR **ACCOUNTABILITY** SUPERVISORY FOCUS

focussing on the quality of care delivered by the supervisee in practice

THE NEED TO DEVELOP THE SKILLS OF THE SUPERVISEE IN CLINICAL SUPERVISION

At first, suggesting that the role of the supervisee as a storyteller may not seem a professional pursuit, but is a useful metaphor for clinical supervision (Driscoll in print). Bowles (Bowles 1995) is surprised at the lack of references to storytelling in the UK nursing literature. He states that British nurses often tell stories within the boundaries of critical incidents, reflective journals, sections of professional portfolios and clinical supervision relationships, but that they do not acknowledge that they are doing it.

The usefulness of the storytelling metaphor in clinical supervision is the active element of the supervisee when recounting what should be a non fiction story to the clinical supervisor. The clinical supervisor pays attention to the practice story, but the essence of a good supervision is in how it was told by the supervisee in the first place. In clinical supervision, the supervisee is very much in control of the content of the story. The clinical supervisory role is assisting the supervisee to derive meaning from the story in order to enhance clinical practice.

Breaking down the practice story into its different sections offers a basic structure for the clinical supervision session (Box 3) and emphasises the role of the supervisee. More importantly, it demonstrates how both parties have to work together in partnership to make the session meaningful.

BOX 3 : HOW THE DIFFERENT SECTIONS OF A PRACTICE STORY CAN GIVE STRUCTURE TO A CLINICAL SUPERVISEE IN A SUPERVISORY SESSION

Adequately prepare for practice storytelling beforehand

- review documentation you have kept / agreed with the supervisor at any previous session
- think about what you want to discuss and make a note of it, or tape record the session with the supervisors permission beforehand
- give yourself plenty of time to get to the venue
- plan your day beforehand / warn others you will need to temporarily leave the practice situation

Opening the practice story

- review what went on in the previous session and check for previous understanding by the supervisor
- check how you are feeling as the storyteller e.g. tired, or something happening that is likely to limit your storytelling ability?
- try to prioritise beforehand some of the most interesting practice stories you may wish to talk about and why they are important
- work out with the supervisor what practice story (ies) you want to tell in the limited time you have together

Telling the practice story

- try to give a full description of what went on in practice using your own words and metaphors to illustrate the situation to the supervisor
- use the opportunity to take the lead in what is your story (ies) and your clinical supervision session
- be willing and open enough to consider different or alternative endings to your practice story(ies)
- record or document any alternative ways of ending the practice story(ies)

Audience reaction (supervisor) to your practice story

- as you tell the story consider some of the reaction of the main characters in your story to what happened other than just your own
- jointly check for understanding of the practice story (ies) told
- listen to the supervisors precis of your practice story (ies), have they fully understood?
- jointly agree with the audience (supervisor) any alternative ways discussed in ending the practice story (ies)
- agree on any plan of action agreed to take into any future practice situation (s)
- record the story as agreed previously in the contractual session
- offer positive feedback to the audience (supervisor) for listening to your story
- check date/time/venue for next session

The success of clinical supervision ultimately rests with the willingness and commitment of supervisee's to engage in it and learn by going through their practice experiences (Bond & Holland 1998), Despite the centrality of the supervisee, much of the literature on clinical supervision has tended to be focussed on the development of clinical supervisors (Tate 1998).

One of the major concerns of new supervisees is often the actual or imagined power differential between themselves and their supervisor, although clinical supervision is not a managerial control system or even a statutory requirement (UKCC 1996). For this reason the remaining part of the article is intended to promote some baseline skills of the clinical supervisee to get the most from their supervision.

In the authors opinion there are 6 baseline skills (Box 4), for supervisee's to consider (Driscoll in print). Rather than being a prescription for supervision they are offered as signposts to empower the less experienced practitioner in what is supposed to be a formalised system of professional development and support in clinical practice (UKCC 1996).

BOX 2 :
SIX BASELINE SKILLS FOR THE SUPERVISEE IN OBTAINING EFFECTIVE CLINICAL SUPERVISION

1) make the session work for you not just the supervisor
2) identify pertinent stories to disclose in the session
3) start to notice your 'self' in clinical practice
4) be open to receive feedback on clinical performance
5) write as well as talk about practice stories
6) adopt a more proactive approach to practice 'problems'

1) MAKE THE SESSION WORK FOR YOU NOT JUST THE SUPERVISOR

Drawing up a contract in clinical supervision is an essential part of sharing the ownership of it (Bishop 1998, Bond & Holland 1998, Dolley et.al. 1998, Fowler 1998,

UKCC 1996). Although getting the contract right does not guarantee successful supervision, it does provide a firm foundation for more effective work (Brown & Bourne 1996). One of the ways it does this, is in clarifying the specific roles and responsibilities each party will have in relation to clinical supervision e.g the clinical supervisee setting the agenda.

Adopting a more 'self'ish approach *before* engaging in clinical supervision, can include getting more information about how it could work for you rather than relying on the supervisor to set the scene.

NOW DO TIME OUT 3:

If you are already in a clinical supervision relationship, when was the last time you reviewed what is going on ? How does what you agreed in your original contract compare with what happens now?

If you have not yet started clinical supervision, read Chapter 3: The clinical supervision relationship : a working alliance in Bond & Holland (1998) or obtain a copy of your organisational Clinical Supervision Guidelines relating to contracting.

If you do not know what to expect, or the purpose of clinical supervision how can you be in control of what happens in the sessions? Remember, you always have a choice as a supervisee to continue with what is happening or move towards something better.

The relationship you have or develop with your clinical supervisor will obviously be crucial to all of this. If you are unhappy with the way things are going in supervision, negotiate a change in your contract, or change your supervisor! It really is better to start clinical supervision at the beginning, by having some informed idea of what you want first and mutually agree on this. Important starting points to consider in a new relationship will be;

BOX 3: IMPORTANT ISSUES TO DISCUSS WITH THE SUPERVISOR IN THE FIRST SESSION

- how often?
- where will it take place?
- at what time?
- what to do in the event of a cancellation?
- when will shall we review what is happening?
- how will confidentiality be maintained?
- what should be documented?
- what shall we do in supervision and how will we know it is happening?
- what are my rights and responsibilities as a supervisee?
- what are the rights and reponsibilities of the supervisor?
- how can I opt out of supervision if I don't get on with the supervisor, (or vice versa)?

2) IDENTIFY PERTINENT STORIES TO DISCLOSE IN THE SESSION:

It has already been suggested that the supervisee's practice story(ies) will form the basis of the clinical supervision session. An essential skill for the supervisee is in prioritising, what practice stories are pertinent to disclose in the session. This is not always straightforward, and may occur for a number of reasons (Box 4);

BOX 4 :REASONS WHY SUPERVISEES FIND IT DIFFICULT TO PRIORITISE WHAT TO DISCUSS IN THE SESSION

- feeling unsafe about disclosing aspects of clinical practice to the supervisor
- not making a note of significant things that have happened in practice since the last supervision session
- using informal chats in practice as a substitute for supervision
- not being used to reflecting on your practice with others in any depth
- not realising a particular story is worth exploring
- being unwilling or anxious about exposing a particular aspect of your clinical practice
- wanting to pack too much in to a short space of quality time that is concerned with YOU
- not being in control of clinical supervision as the supervisee
- reflecting the developmental level of an inexperienced supervisee

You as a supervisee, also have as much responsibility in keeping what goes on in the session confidential. Not keeping out of clinical supervision what you thought of a supervisor's performance, is just as important as what you think the supervisor is thinking about your performance as a practitioner! Fear of a lack of confidentiality in the clinical supervision relationship requires urgent discussion, perhaps by a third party, as it will obviously affect what pertinent stories are witheld from clinical supervision.

Not all the time spent in supervision will be relating new practice stories. The early part of the session is likely to be reflecting upon how you have managed something (or not), that came up in the last session.

NOW DO TIME OUT 5:

For those unable to think of something to talk about in a supervision session (which is very unlikely), you may instead wish to consider completing some of the following sentences at the end of a shift;

- something that went well for me today was.....
- I really felt a nurse today because.....
- what really drove me mad today was when .....
- what I attempted to do in this situation was .....
- something that bothers me about what I do is .....

- I really think I need more information about .....
- what really puzzled me today was .....
- If I had the chance to do that again I would .....
- I felt really stupid about .....

Notice not all of those instances are negative ones, some are positive practice experiences as well. Clinical supervision will become a very negative experience and demoralise the supervisee if the focus is always on the bad side of practice. It can be quite enlightening to recall an instance that you were pleased about. The focus can then change to "in what way did you think this was good, what did you say or do?"Exploring "why?" can be a major source of learning as the supervisee begins to understand the answer to the question and try to repeat good practice again.

3) START TO NOTICE YOUR 'SELF' IN CLINICAL PRACTICE

Morrison & Burnard (1993) consider the self as being integrated into three domains the thinking, feeling, and behaving self. Thoughts, are the mental processes which include such things as ideas, how to solve problems and consider different ideas. Feelings, are the emotional aspects of the self, whilst behaviour relates to what we do.

Clearly it is not possible to notice all of our actions and behaviours all of the time. Clinical supervision is an intentional activity in which the supervisor can help the supervisee begin to become more aware of the 'self' operating in clinical practice and choose between different actions based on previous ones. What John Heron (1989) refers to as the *conscious use of the self* .

Noticing the 'self' in clinical supervision is an intentional activity initiated by the supervisee. Although the clinical supervisor can encourage this, he/she cannot prescribe it. One of the biggest challenges for the clinical supervisee is to not only notice the self from the comfort of the supervision armchair, but to put some of what is noticed back into clinical practice. Much will depend on the supervisory approach, or in answering the question what shall we do in supervision and how will we know it is happening?

Hawkins & Shohet (1990) offer two broad approaches to clinical supervision from the disciplines of counselling and psychotherapy, that have been widely publicised in the nursing literature (Butterworth & Faugier 1994, Farrington 1995, Hughes & Morcom 1996), and can be simplified as *Reflection - on - practice* (looking to the past to see the future), and *Parallel Processing* (looking at the present to see the future).

NOW DO TIME OUT 6:

Obtain both journal articles by Marrow et. al. (1997) and Playle & Mullarkey (1998). Write short notes comparing the different approaches that both sets of authors adopt

towards clinical supervision. Can you recognise the approach you are using in your own supervision or think might be interesting if you are about to start clinical supervision? How would you now address the question if your clinical supervisor asked "How shall we spend the time in supervision together?"

For many mental health nurses working in the midst of intense therapeutic relationships, a more in depth supervision utilising *Parallel Processing* rather than *Reflection on Practice* may be preferred. Both require that the learning from supervision be translated in some way back into clinical practice. But how might this be evidenced? After all, clinical supervision is not a therapeutic relationship, although it is an opportunity to become more aware of clinical practice.

4) BE OPEN TO RECEIVE FEEDBACK ON CLINICAL PERFORMANCE

As with many of the skills of the supervisee, being open to receive feedback on clinical performance may seem obvious in clinical supervision. This can be troubling not just for supervisees, but to supervisors as well, particularly where the supervisor has known the supervisee for some length of time. McEvoy (1993) states that many nurses on the unit before clinical supervision was introduced, felt that they were only told when there clinical performance was not up to scratch, and given little positive feedback on their overall performance.

Feedback is not failure. Failures are another way of describing something you did not anticipate or want to happen. Feedback is an opportunity to learn from something you had not noticed as a supervisee, but the clinical supervisor did. Whilst clinical supervisors need to consider ways of giving feedback to supervisees, for supervisee's it may be a time to consider how to receive it! Helen Seijo (1996) offers the following points (Box 5).

BOX 5 : WAYS OF RECEIVING FEEDBACK FROM THE CLINICAL SUPERVISOR

- **Ask for feedback in a way that gives reassurance to the supervisor that you will not be offended if views are expressed openly**
- **Listen carefully to what is said by the supervisor, although you may feel uncomfortable. Resist the temptation to argue, explain or disagree.**
- **Clarify what the supervisor is saying to you by asking questions <u>after</u> the feedback has been given.**
- **Ask for suggestions about alternative ways of behaving**
- **Take some time to decide whether you wish to act on the information**
- **Thank the supervisor for responding openly to your request for feedback. It may not have been easy for the supervisor**

5) WRITE AS WELL AS TALK ABOUT PRACTICE STORIES

Historically, nursing has been taught on the premise that there is a right way to go about practice. Not surprisingly when confronted with writing a reflective diary or supervision notes for the first time, supervisee's invariably require some ressurance they are doing it the right way. Street (1995) suggests that beginning to write about ones' clinical practice is not only about overcoming the hurdles of finding the time and describing our thoughts, feelings and behaviour in written form, but also having the sneaky suspicion that the effort put in may not really be worthwhile.

The discipline of writing is related to noticing the 'self' in practice by turning an often unconscious practice activity into a deliberate and conscious act as discussed earlier. In clinical supervision, 'freezing the action' (Butcher 1995), by writing about practice, will assist the supervisee as well as the clinical supervisor to examine practice from a number of different perspectives.

Keeping a written journal as an aid to storytelling is a useful supervisee skill. There is becoming an association between keeping a reflective journal or log in nursing literature and clinical supervision (Ghaye & Lillyman 1997, Johns & Freshwater 1998, Fisher 1996). At the very least, the UKCC (1998, 1997, 1996) advocate supervision records are kept, with many organisations now agreeing that the supervisee keeps them within their professional portfolios as evidence of maintaining professional registration as well as maintaining confidentiality.

NOW DO TIME OUT 7:
Find a particular reflective model that you have heard or read about and suits your own style of writing. It may be worth asking anyone you know who is either on a pre registration or continuing education course. Then go back to TIME OUT ACTIVITY 5 and compare how using a structured method of written reflection compares to what you originally did.

From a personal perspective as a clinical supervisor and supervisee, my own clinical supervisor feels that keeping a reflective account of incidents demonstrates a level of preparation and commitment that clinical supervision time is not just an idle chat, but a purposeful activity. If the supervisee can also produce a written summary at the beginning of supervision of what went on in the last session, it can be beneficial to both parties and help tune in to the session quickly.

6) ADOPT A MORE PROACTIVE APPROACH TO PRACTICE 'PROBLEMS'

Although clinical supervision does not only have to be about supervisee 'problems' invariably the sessions can start out like that. This may be demonstrating the particular level that the supervisee is at, or that supervisee's in nursing practice value this approach the most. It is interesting when I challenge the supervisee to bring something

in that went well for a change. This is not surprisingly, more challenging for the supervisee, often used to adopting a 'problem' orientated approach to clinical care using the nursing process. Although probably one of the first reflective tools in nursing, it tended to get stuck at 'thinking about' rather than 'actioning' nursing problems.

Traditional models of psychiatry or psychotherapy also tend to to focus on the clients 'problems' by exploring the past in some detail to help develop insight into why a 'problem' emerged and help the client understand why they feel and behave in a particular way. It is interesting to view clinical supervision in such a traditional 'medical model' where the supervisee comes to supervision with problems. These problems are then solved by the supervisor. It is perhaps an attractive option for the supervisee already used to a problem orientated approach to nursing care, for the supervisor who can be in a position of authority and control, and for the organisation to feel secure that problems from practice are being attended to.

An alternative can be to adopt a more solution approach to clinical supervision. nursing practice. Solution focused therapy is a method developed by De Shazer (1985) that concentrates on peoples' competence rather than their deficits, their strengths rather than their weaknesses and possibilities rather than limitations. This alternative approach has been successfully utilised by mental health nurses (Hawkes et.al. 1993) and could be adapted for an alternative model of clinical supervision. In other words, clinical supervision that concentrates on exploring solutions, rather than the clinical supervisor attempting to analyse the 'problem' the supervisee has in their clinical practice.

The clinical supervisor then becomes concerned with how the supervisee would like his / her clinical practice to be like when the problems are solved, look for when it does already occur, and work to create the conditions for it to happen more often. Wilgosh et.al. (1994) citing Milton Erikson, sum up the potential of this approach;

"The client (clinical supervisee?) often knows what to do to solve his problem but does not know that he knows"

This approach to clinical supervision at the very least allows a way of questioning that enables supervisee's and supervisee' to think about solutions in a more proactive way, rather than focus on why the problem has happened, or is happening. You may wish to further explore (if you are not already familiar), some of the underlying principles of finding solutions, rather than concentrating on supervisory 'problems'.

CLINICAL SUPERVISION: A MANDATE FOR PERSONAL CHANGE IN PRACTICE?

This article has briefly reviewed what the aims of clinical supervision are for nursing practice and questioned whether it is already happening in your practice. Many of the

skills of the supervisee have yet to be fully identified, as there remains a dearth of literature in comparision to that of the clinical supervisor. You may wish to consider that many of the skills of the clinical supervisee illustrated are transferable from practice. Finally, I would again suggest that the clinical supervisee will determine the outcome of clinical supervision in nursing, and hope that this introduction to the skills of the supervisee, provokes your own mandate for developing mental health nurse specific knowledge for clinical supervision.

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MULTIPLE CHOICE ASSESSMENT: GETTING THE MOST FROM CLINICAL SUPERVISION(1) : THE SUPERVISEE

1) Which of the following is generally recognised by the nursing leadership as an essential reason for clinical supervision in practice?
a) the development of reflective practice
b) the development of clinical leadership
c) the development of mental health nursing
d) the development of clinical competence
e) the development of a generic European nurse

2) Which of the following disciplines is clinical supervision NOT usually associated with?
a) social work
b) psychotherapy
c) counselling
d) mental health nursing
e) adult nursing

3) Which of the following is NOT usually associated with Proctor's (1986) Interactive Model of Clinical Supervision?
a) talking about colleagues practice
b) professional development
c) learning
d) stress reduction
e) monitoring a supervisee's work

4) Which in your opinion best describes management supervision?
a) sharing professional knowledge
b) supporting a distressed colleague
c) examining a piece of work through critical reflection
d) reflecting on why something did not go well in practice
e) monitoring a clinical practitioner at work

5) Why is establishing an agreement important in clinical supervision for the supervisee?
a) to avoid being late for the session
b) to work out who will be in charge of the session
c) to develop trust
d) to establish boundaries about what is expected of each other
e) to individualise clinical supervision

6) Clinical supervision can be helpful for mental health nurses because it:

a) is an opportunity for getting formalised feedback on clinical practice
b) it can solve all the problems of clinical practice
c) is a way of relaxing during a busy shift
d) will help retain staff
e) is a safe place to talk about other staff

7) Clinical supervision can demoralise supervisees if:
a) they always arrive late for the session
b) the focus is always about what went wrong in practice
c) the supervision room is too cold
d) they are already a senior practitioner
e) the supervisor is not a personal adviser

8) Which in your opinion is NOT a way for the supervisee to receive feedback from the supervisor?
a) listening carefully to what is said
b) asking for suggestions for alternative ways of behaving
c) clarifying with the supervisor what has been said
d) telling the supervisor that they will not be offended by their feedback
e) telling the supervisor to only give positive feedback to you

9) The main reason for keeping records in supervision is:
a) so the supervisor does not forget what was discussed
b) to be used as evidence of not being a good practitioner
c) to keep the supervisee 'on their toes' in clinical practice
d) to enhance entries in clients case notes
e) because they are evidence of maintaining professional registration

10) What is the purpose of any clinical supervision model in nursing?
a) to help be a more efficient practitioner
b) to help prioritise the work
c) to help eventually to get on a related educational course
d) to help to enhance client care
e) to help identify why you are having problems at work

THE REMAINING QUESTIONS 11 - 20 RELATE TO APPLYING CLINICAL SUPERVISION IN THE FOLLOWING SCENARIO:

Suresh qualified just over a year ago as an RMN and is working on an EMI unit. Over the last month he has become quite attached to Barbara, a 68 year old woman admitted to the unit with behavioural problems associated with Alzheimers Disease. As her key worker, Suresh has become concerned about the disinhibitive behaviour of Barbara which has caused two relatives to make formal complaints to the nurse in charge. Although he has been receiving monthly clinical supervision he has not yet discussed Barbara with his clinical supervisor.

11) What do you consider might be the benefit of Suresh discussing Barbara with his supervisor?
a) he could find out more about Alzheimers Disease
b) he could find out more about dealing with complaints
c) he could find out more about dealing with inhibitive female clients
d) he could obtain some confidential professional support
e) he could solve his practice problems

12) What aspects of Suresh's clinical care is the supervisor unlikely to be concerned with?
a) the feelings he has for the relatives who complained
b) the feelings he has for Barbara
c) how he is managing the care programme for Barbara
d) how he could minimise his responsibilities as the key worker
e) what previous experience he has of dealing with disinhibitive behaviour

13) What is one of the main ways that Barbara could benefit from Suresh seeking out clinical supervision?
a) he would be less embarrassed with her behaviour
b) he would learn how to avoid her in future
c) he could stand up to the relatives better
d) he would not feel as concerned about her as he has been
e) he could explore ways of promoting her dignity on the unit

14) What important skill can be developed by Suresh in clinical supervision to enhance his clinical practice?
a) maintaining a safe environmnent
b) how to be more in control of the situation
c) better assessment techniques of EMI clients
d) how to handle complaints
e) obtaining honest feedback about his clinical performance

15) What in your opinion is an inappropriate topic for Suresh to talk about in clinical supervision?
a) guilty feelings about the two complaints
b) reviewing Barbara's care programme
c) ways in which relatives complaints can have maximum impact
d) the progress Suresh has made during one year on the unit
e) ways in which Barbara's behaviour affects the behaviour of other clients in the unit

16) Whilst talking about Barbara, Suresh discloses to the supervisor that he wishes he could run away from the session, the supervisor replies that what could be going on is;
a) a reflective process
b) an embarrassing process
c) a parallel process
d) a reactive process
e) a nursing process

17) Suresh remarks that clinical supervision is like a therapy used on the unit. The supervisor explains that clinical supervision differs because;
a) not all supervisors are healers
b) you don't need to be a psychotherapist
c) it does not have any therapeutic effects
d) the emphasis is on clinical practice
e) you do not have to pay for it

18) The clinical supervisor can help Suresh with his key working role by;
a) confronting him with poor aspects of key working practice
b) being more senior to him in management
c) exploring with Suresh what concerns he has about key working
d) telling him what to do
e) giving him the benefit of his experience

19) What in your opinion might NOT help Suresh to discuss his concerns about Barbara in clinical supervision?
a) having a choice of clinical supervisor
b) having a clinical supervisor visit that is external to the unit
c) having an awareness of reflective practice
d) having been made aware of the supervisor talking about a previous supervision session to a practitioner in the coffee room
e) having had an opportunity to discuss boundaries in the first session of clinical supervision

20) The supervisor asks Suresh whether he was going to write up what had gone in the session as regards Barbara as it was important to:

a) to be more self aware of what was going on in practice
b) practice writing for better care records
c) remind the supervisor what went on in the next session
d) use a structured model for reflection
e) describe clinical practice

MULTIPLE CHOICE ASSESSMENT: GETTING THE MOST FROM CLINICAL SUPERVISION(1) : THE SUPERVISEE

ANSWER SHEET

1. d) the development of clinical competence
the emphasis should be on the practitioners work

2. e) adult nursing
all the others have had at least heard of supervision

3. a) talking about colleagues practice
supervision is not a gossip shop and is concerned with individual practice

4. e) monitoring a clinical practitioner at work
a valid element of mangerial supervision

5. d) to establish boundaries about what is expected of each other
this protects the supervisee from the supervisor and vice versa

6. a) is an opportunity for getting formalised feedback on clinical practice
all the others are assumptions about clinical supervision

7. b) the focus is always about what went wrong in practice
persistent negative feedback will put off the supervisee

8. e) telling the supervisor to only give positive feedback to you
this is not a valid way of enhancing clinical practice

9. e) because they are evidence of maintaining professional registration
Included as a reason in the UKCC position statement on clinical supervision

10. d) to help to enhance client care
the emphasis must be on what happens with the client

MULTIPLE CHOICE ASSESSMENT: GETTING THE MOST FROM CLINICAL SUPERVISION(1) : THE SUPERVISEE

ANSWER SHEET

Suresh qualified just over a year ago as an RMN and is working on an EMI unit. Over the last month he has become quite attached to Barbara, a 68 year old woman admitted to the unit with behavioural problems associated with Alzheimers Disease. As her key worker, Suresh has become concerned about the inhibitive behaviour of Barbara which has caused two relatives to make formal complaints to the nurse in charge. Although he has been receiving monthly clinical supervision he has not yet discussed Barbara with his clinical supervisor.

SCENARIO QUESTIONS:

11. d) he could obtain some confidential professional support
one of the aims of clinical supervision from the Department of Health

12. d) how he could minimise his responsibilities as the key worker
clinical supervision is not an abdication of practitioner responsibilities

13. e) he could explore ways of promoting her dignity on the unit
emphasis on delivery of client care

14. e) obtaining honest feedback about his clinical performance
clinical supervision is about getting feedback on practice

15. c) ways in which relatives complaints can have maximum impact
this is counter productive to clinical practice although advocacy is important

16. c) a parallel process
a particular supervisory technique

17. d) the emphasis is on clinical practice
clinical supervision is practice focussed

18. c) exploring with Suresh what concerns he has about key working
clinical supervision is not about telling someone what to do

19. d) having been made aware of the supervisor talking about a previous supervision session to a practitioner in the coffee room
lack of trust and breaking confidentiality

20. a) to be more self aware of what was going on in practice
reflective writing increases self awareness

Clinical Supervisee Self Assessment Tool

Read the following statements and tick the box that you feel accurately reflects the statement in relation to your own supervisory practice.

Supervisory Statement	*Always*	*Sometimes*	*Never*
1 I let the supervisor open the session			
2 I let the supervisor know what the session will be about			
3 I spend time thinking about the session beforehand			
4 I ask the supervisor to alter aspects of the session I am unhappy about			
5 I leave the supervision session more knowledgeable about my clinical practice session			
6 I can work out what practice stories to recount in the supervision session			
7 I make a note of different things that happen in practice that will be useful in supervision			
8 A large part of the session is discussing practice that happened some time ago			
9 I talk to the supervisor about things that went well in my practice			
10 I talk about my supervisor outside of the session			
11 The supervisor make me aware of what I do in my clinical practice			
12 Supervision sessions helps me focus on my feelings about clinical practice			
13 I am a thoughtful clinical practitioner in supervision			
14 I am a thoughtful practitioner in my clinical practice			
15 I see how what is discussed in clinical supervision relates to me as a practitioner			
16 I view clinical supervision as a positive learning experience			

Clinical Supervisee Self Assessment Tool contd.

17 I act on what I hear about in the session from the clinical supervisor

18 I am not offended by the feedback my supervisor gives me

19 I thank the supervisor for being open with me at the end of the session

20 I ask the supervisor for feedback on specific elements of my clinical practice

21 I write about my clinical practice other than the usual nursing documentation at the end of a shift

22 I write up my clinical supervision sessions and keep a record of them

23 I prepare for the session ahead by writing about what I wish to talk about in the session

24 I store my clinical supervision notes in my professional portfolio

25 I use a reflective framework when writing up my supervision notes

26 I talk about my problems regarding clinical practice in the supervision session

27 I talk about problems regarding clinical practice in the supervision session that really belong to others

28 Clinical supervision concentrates on my competence and strengths as a practitioner

29 I have an idea of how I would like my clinical practice to look and discuss this in the supervision sessions

30 My clinical supervision focusses on solutions rather than clinical practice problems

Check each of your answers on the answer grid. Score 3 marks for Always, 2 marks for Sometimes, and 1 mark for Never. Total each of your baseline scores. The maximum score for each of the six skills is 15, the minimum score for each of the six skills being 5 marks. You may wish to do this exercise again in six months time to notice the progression made as a clinical supervisee.

Taken from: Driscoll,J.J. (in print) *The Practice of Clinical Supervision: A Reflective Approach* Bailliere Tindall (in association with the Royal College of Nursing) Publishing, London,UK.

Clinical Supervisee Self Assessment Tool

Plot the total scores on the bar graph from each question you answered and rate yourself against each of the six baseline skills of the the maximum totals available.

You know have formed your personal baseline from which to begin to think about gauging your own performance as a clinical supervisee. On reflection, what sort of things have you learned and need to action in your clinical supervision?

SIX BASELINE SKILLS OF THE SUPERVISEE	ability to make the session work for your practice	ability to disclose relevant practice stories in supervision	ability to notice your 'self' in practice	ability to receiving feedback about practice	ability to write as well as talk about practice	ability to be proactive in seeking solutions in supervision
Question answered	4	12	2	6	24	22
Your score for question						
Question answered	14	23	10	3	15	8
Your score for question						
Question answered	20	18	27	7	1	19
Your score for question						
Question answered	28	25	16	30	11	13
Your score for question						
Question answered	9	29	21	17	26	5
Your score for question						
maximum score for each of the six baseline skills	15	15	15	15	15	15
TOTAL YOUR SCORES IN EACH OF THESE ROWS						
minimum score for each of the six baseline skills	5	5	5	5	5	5

Taken from: Driscoll,J.J. (in print) *The Practice of Clinical Supervision: A Reflective Approach* Bailliere Tindall (in association with the Royal College of Nursing) Publishing, London,UK.

Look at Seijo's diagram in Figure 1 outlining two different dimensional lines of supervision. The two dimensions being that supervisory activities can either be Formal/Informal or Planned/Ad-Hoc. The four quadrants that emerge illustrate the range and different types of supervisory activities going on in social work.

Figure 1 Dimensions of supervisionCOPYRIGHT?

FORMAL
Supervision is the primary task

Groups or individuals
Agreed agenda
Agreed method for reaching objectives
Agreed period of time
frequency
Agreed venue without interruptions

Groups or individuals

Agenda agreed on the spot
to deal with unforseen Agreed
event

PLANNED
Agreed in advance

Group or individuals
Purpose agreed in advance
Forms of feedback agreed
in formal session

AD-HOC
Response to an event

Groups or individuals

Agenda agreed on the spot Later discussed
to deal with unforseen
event

Feedback or demonstration
that can be discussed later
in a formal session

INFORMAL
Service delivery continues

Looking at supervision through Seijo's different dimensions gives an indication of the variable nature and roles of being a supervisor or being supervised in nursing. It relates to the 'where' and 'when' of supervision. Sometimes unexpected opportunities emerge outside of planned supervision.

THINKING SPACE (ROCKET,STARS,MOON ICON)
What is happening already?

Individually, or as a group activity, compare the different dimensions of supervision with what occurs in your own clinical practice area. What activities can you think of that could be considered nursing supervision within each of the four quadrants suggested by Seijo? Do you agree with my own ideas of the two dimensions of supervisory activities in clinical nursing practice (Fig. 2)?

Fig.2 Dimensions of supervisory activities in clinical nursing practice

FORMAL
Supervision is the primary task

Clinical Supervision

Management Supervision

Caseload Supervision

Appraisal/Performance Review

Student practice assessment

Clinical Audit

Mentoring/Preceptorship

Debriefing following critical incident

Student feedback on performance

Mentoring/Preceptorship

Instant feedback on performance during or Disciplinary procedures following a significant event

PLANNED
Agreed in advance

Peer Review

Professional Groups/Forums

Teaching session

Ward/Team meeting

Case conferences

Shift Handovers

Feedback on attendance at study day(s)

AD-HOC
Response to an event

Immediate advice/support in dealing with a current problem or situation

Impromptu teaching session

Networking with others

General information giving to each other to carry out nursing practice

Demonstration of a practical skill

Ward placement evaluation by student

INFORMAL
Service delivery continues

Looking at supervision through Seijo's different dimensions gives an indication of the variable nature and roles of being a supervisor or being supervised in nursing. It relates to the 'where' and 'when' of supervision. Sometimes unexpected opportunities emerge outside of planned supervision.

THINKING SPACE (ROCKET,STARS,MOON ICON)
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Individually, or as a group activity, compare the different dimensions of supervision with what occurs in your own clinical practice area. What activities can you think of that could be considered nursing supervision within each of the four quadrants suggested by Seijo? Do you agree with my own ideas of the two dimensions of supervisory activities in clinical nursing practice (Fig. 2)?