This is the second (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 (2): THE SUPERVISOR

AIMS AND INTENDED LEARNING OUTCOMES

This the second of two articles, outlines some of the baseline skills of the clinical supervisor to help maximise the time spent during clinical supervision sessions. It is aimed predominantly at practitioners's engaging in one to one clinical supervision as supervisors 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
- 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 supervisor
- Based on your personal reflections plan how as a supervisor you can enhance what you may already offer the supervisee in clinical supervision sessions

INTRODUCTION

The previous article (Driscoll 1999), viewed clinical supervision from the perspective of a clinical supervisee, and introduced the concept for practitioners who may have been unfamiliar with the term. It also attempted to redress much of the current literature on clinical supervision in UK nursing and health visiting, that Tate (1998) suggested overemphasised the preparation of clinical supervisors, at the expense of clinical supervisees.

Because of the historical development of clinical supervision within psychotherapy, counselling and social work, supervision is unlikely to be an unfamiliar term for mental health nurses (Morris 1995), but still not yet the norm for the majority of those practitioners (Carson et.al. 1995, Kipping 1998). For newer practitioners, clinical supervision is simply a continuation of preceptoring and mentoring schemes already in operation. For more traditionally qualified practitioners, the challenge is to begin to regularly engage in more formalised support, and obtain feedback about their clinical practice from a designated clinical supervisor.

Bishop (1998) defines clinical supervision and summarises from the available literature, what the main aims of the initiative are that will be helpful to new clinical supervisors (Box 1). Whilst this highlights the need for adequate preparation of clinical supervisors, it is important for practitioners not to simply adopt other peoples ideas about clinical supervision, but consider adapting aspects of their existing practice into the clinical supervision encounter.

BOX 1:
AN OPERATIONAL DEFINITION 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.

THE AIMS OF CLINICAL SUPERVISION IN PRACTICE:
- to safeguard standards of practice
- to develop the individual both professionally and personally
- to promote excellence in healthcare

Bishop (1998)

THE FUNCTIONS OF THE CLINICAL SUPERVISOR IN PRACTICE
Brigid Proctor's (1986) much cited Interactive Model of Clinical Supervision, describes the three key functions of the clinical supervisory role that are not dissimiliar to the aims of clinical supervision outlined by Bishop (1998). Rafferty et.al. (1998), have adapted the three functions to make the terminology easier to understand (Figure 1).

FIGURE 1:
PROCTOR'S (1986) INTERACTIVE MODEL OF SUPERVISION INCORPORATING THE THREE KEY FUNCTIONS OF THE CLINICAL SUPERVISOR

FORMATIVE OR **LEARNING*** SUPERVISORY FUNCTION

facilitating the supervisee's professional development

RESTORATIVE OR **SUPPORT*** SUPERVISORY FUNCTION

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

THE SUPERVISEE IN CLINICAL SUPERVISION

NORMATIVE OR **ACCOUNTABILITY*** SUPERVISORY FUNCTION

focussing on the quality of care delivered

by the supervisee in practice

* Rafferty et.al. (1998)

In this model of clinical supervision, the three supervisory functions seem to apply equally, in reality, they will inevitably overlap depending on what the supervisee feels is important to discuss, and the role the supervisor feels is appropriate to adopt in the session. For new clinical supervisors it can be helpful to think about Proctor's (1986) model in relation to what is already being done in clinical practice. Many supervisory skills are readily transferable from within clinical practice.

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. Using Proctor's (1986) three supervisory roles, compile a list of potential supervisory functions that you feel you already might be performing in your clinical practice.

Many of the functions you perform, will obviously have been related to the role you are employed for in clinical practice. It is worth considering whether any preferred ways of engaging in clinical practice emerge e.g. a tendency to support people, rather than facilitate learning, or formally manage people or situations. Might such preferred ways of engaging in clinical practice also spill over into the way you are likely to function as a clinical supervisor, and what may be the implications for your supervisees? This is explored in greater depth by Hughes & Pengelly (1997) as 'supervisory triangles'.

Although clinical supervision is not intended to be hierarchical, or a managerial control system (UKCC 1996), there is an emerging relationship between clinical supervision and clinical governance (Butterworth & Woods 1999), clinical risk management (Neal 1998,Tingle 1995) and quality care (Nicklin 1995). Proctor's (1986) model is a useful tool for new clinical supervisors to reflect on actual, or potential, supervisory performance with the supervisee, as there may be elements of the model that are preferred, or avoided altogether, limiting the usefulness of the broader intentions of clinical supervision.

CONTRACTING IN CLINICAL SUPERVISION
A supervision contract is arguably one of the most essential ingredients that underpins the success of the supervisory relationship (Bishop 1998, Bond & Holland 1998, Dolley et.al. 1998, Fowler 1998, UKCC 1996). It is a negotiated agreeement which identifies ground rules about the supervision process (Gadd & Mahood 1995:13).

However, the fact that conditions might exist for clinical supervision in professional nursing, does not necessarily mean that this will be shared by those engaging in it. For engagement to occur in clinical supervision between the supervisor and supervisee, Morrison (1996) suggests that there must be;

.....a shared perception of, and commitment towards, supervision by both parties, based on clarity about agreed roles, responsibilities and expectations, and some understanding of the relevant past that each brings to the supervisory process.

A precontractual meeting between the supervisor and supervisee can be helpful to explore each others hopes, fears and expectations about clinical supervision. It is an opportunity to discuss the practicalities as well as agreeing on the likely content of supervision sessions (Box 2). As a clinical supervisor, it is important to formally agree on what it is the supervisee wants to get out of what is essentially *their* clinical supervision time. At the same time it is useful to explore any 'supervisory baggage' you may BOTH be bringing with you into the clinical supervision room, BEFORE you agree to engage in clinical supervision formally. Differentiating how in each others opinions clinical supervision might be different, starts the process of trusting each other and is a pre requisite for the creation of a supportive supervisory relationship (Wilkin 1999).

BOX 2:
SOME SIGNPOSTS FOR AGREEING THE ORGANISATION OF CLINICAL SUPERVISION SESSIONS AT THE FIRST MEETING

THE PRACTICALITIES OF SUPERVISION:

- how often?
- length of sessions?
- where will it take place?
- do any rooms need to be booked in advance?
- how can supervision fit in to existing responsibilities and workload?
- are there good times for both parties?
- what is the procedure if a session has to be cancelled?
- what are reasonable / unreasonable grounds for cancelling?
- is the environment conducive to being able to think about practice?
- how is confidentiality to be maintained e.g.recording sessions?
- what happens in the event of not getting on with one another in supervision?
- mutually agree a time in advance to review how clinical supervision is going

THE CONTENT OF SUPERVISORY SESSIONS:

- what individual expectations do you each have of one another?
- who is responsible for setting the agenda and how will this be done?

- how will time be weighted towards the issues raised in supervision?
- what might be considered priority issues to discuss?
- are you both clear about what you can talk about in sessions?
- what are acceptable ways of giving feedback to one another?
- what are not acceptable ways of giving feedback to one another?
- is anything not acceptable to discuss in clinical supervision?
- when do personal issues obscure professional ones?

NOW DO TIME OUT 2:

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). How does this compare or contrast with your organisational Clinical Supervision Guidelines relating to contracting?

If one accepts the first session or a precontractual meeting as agreeing what is intended to happen in clinical supervision, how are sessions likely to be structured after this? Any organisational Clinical Supervision Guidelines available to you will also offer a framework. In an earlier activity you considered some of the potential supervisory functions that you already perform in clinical practice. Box 3 offers a basic structure for a clinical supervision session and how some everyday mental health skills from practice might readily be transferred into ongoing sessions by the supervisor.

BOX 3:
TRANSFERABLE SUPERVISORY SKILLS FROM CLINICAL PRACTICE THAT CAN BE USED IN ONGOING CLINICAL SUPERVISION SESSIONS

POSSIBLE STRUCTURE FOR A CLINICAL SUPERVISION SESSION	SOME TRANSFERABLE SUPERVISORY SKILLS FROM PRACTICE
prepare for session by reminding oneself what went on previously	**organisational** e.g filing session notes, record keeping **memory** e.g. remembering the person in supervision
supervisor has a responsibility for ensuring a conducive environment	**managerial** e.g. checking venue too hot, cold.... noisy, coffee? **interruption control / privacy** e.g. do not disturb sign, pager/phone off or diverted door closed, out of earshot of others
start the session on time	**time management** e.g.session planned, anticipated for, demonstration of a **commitment to clinical supervision** in busy work schedule
review what went on in the previous session and follow up issues where necessary	**relationship skills** e.g giving full attention, **re-establishing the supervision partnership**, **clarifying** what went on before
find out how each other are feeling before agreeing on a fresh agenda	**self awareness** e.g. obstacles to effective communication and reflective practice, genuineness
prioritise the agenda	**understanding** of the function of clinical supervision
supervisee describes a practice related issue(s) to the supervisor	**relationship skills** e.g acceptance being **non judgemental, facilitation of reflective practice**
supervisor listens and gives feedback to the supervisee	**active listening skills** e.g. an understanding of how to give **effective feedback** to the supervisee
jointly analyse issues and work out together ways of moving forward	**analytical skills** e.g. **questioning** technique, **intervention style** of supervisor

BOX 3 continued:
TRANSFERABLE SUPERVISORY SKILLS FROM CLINICAL PRACTICE THAT CAN BE USED IN ONGOING CLINICAL SUPERVISION SESSIONS

POSSIBLE STRUCTURE FOR A CLINICAL SUPERVISION SESSION	SOME TRANSFERABLE SUPERVISORY SKILLS FROM PRACTICE
supervisor clarifies and summarises what has been discussed in the session	**understanding how the supervisee can learn** from the experience of clinical supervision, **summarising** skills, **active listening** during the session, **intervention style** of supervisor
record session as previously agreed	**relationship skills** e.g. trust, confidentiality, honouring or re-visiting agreements made in the first session as regards documentation and recording
ask supervisee for feedback on supervisor performance	**accepting feedback** e.g. being open, non defensive and **willing to learn** from the supervisee **being aware of how supervisor performance can be evaluated**
check date/time/venue for next session	**organisational skills** **commitment** to role

6 BASELINE SKILLS OF A CLINICAL SUPERVISOR

Despite much of the literature that often lists what clinical supervisor skills are, always consider them in relation to what you are doing already. What actually goes on will also be dependent on the skills of the supervisee, as well as the supervisor. It is therefore important to first identify things that go well in supervision, develop these skills and disseminate them to others. In this way a body of supervision knowledge will begin to emerge in nursing based on critically reflecting on the process of supervision.

Based on some early work in workshops with supervisees and supervisors, six baseline skills are identified (Box 4) for giving effective supervision. It is unlikely that every supervisor will be competent in each of these at first, but are often considered in any initial clinical supervisor training. These can then be added to in further reading, or engaging in more advanced courses in supervision. Different approaches and styles of clinical supervision for mental health practice can also be found in Butterworth et.al. (1998), Farrington (1995) and Playle & Mullarkey (1998). Whichever supervision model

is adapted for practice, it is important that all parties involved, are aware of the process that supervision is taking, including managers.

BOX 4:
SIX BASELINE SKILLS FOR GIVING EFFECTIVE CLINICAL SUPERVISION

1) **open an emotional supervisory account / consider relationship skills**
2) **be willing to mutually learn from engaging in clinical supervision**
3) **be attentive to what is going on in the session**
4) **use effective questioning to help the supervisee notice themself in clinical practice**
5) **be open to receive as well as give feedback on practice**
6) **be able to summarise the content of the session with the supervisee**

1) open an emotional supervisory account / consider relationship skills

All relationships progress through phases regardless of whether the relationship is with a person, project or setting. Intuitively, it is probably apparent that therapeutic relationships in clinical practice, as well as personal relationships flourish or flounder on being perceived by both parties as becoming connected or 'dis'connected in some way.

In supervision, the supervisee and supervisor take on roles and tasks that are required for the relationship to progress or flounder. Covey (1992: 185 - 203) uses the metaphor of an emotional bank account to describe the development of relationships and is a useful way of considering the supervision relationship;

In a financial bank account we make deposits into it and build up a reserve from which we can make withdrawals when we need to. An emotional bank account describes the amount of trust that has been built up in a relationship. Its the feeling of safeness you have with another human being. Deposits such as courtesy, kindness, honesty and being committed build up a reserve. Your trust towards me becomes higher and I can call upon that trust many times if I need to. When the trust account is high, communication is easy instant and effective. If I have a habit of showing discourtesy, disrespect, cutting you off, betraying your trust, eventually my emotional bank account gets very low. To be sustained continuing deposits are necessary.

Covey (1992)

NOW DO TIME OUT 3:
Write short notes about a patient / client in practice you are involved with, that you *find challenging* as a practitioner. What would your emotional bank balance look like as regards deposits and withdrawals, if you asked that patient / person to make up your account as a nurse before they were discharged?

Now write short notes about a different patient / client in practice you are involved with, that you *really like* as a practitioner. How does your emotional bank statement look like as regards deposits and withdrawals, if you asked that patient / person to make up your account as a nurse before they were discharged?

You might like to compare your own reflections in the previous activity, with some deposits and withdrawals a clinical supervisor could make with a supervisee during a session (Box 5). How might contracting help to maintain a healthy emotional supervisory account with the supervisee?

BOX 5:
SOME POTENTIAL SUPERVISORY DEPOSITS AND WITHDRAWALS MADE DURING A CLINICAL SUPERVISION SESSION

DEPOSITS	WITHDRAWALS
being on time for the session	hurrying the session because of supervisor lateness
allowing time for the supervisee to tell their	constantly interrupting the supervisee practice story
being willing to travel to a session	only seeing the supervisee in the supervisors ward office
providing some refreshment	wanting to get on because of a meeting afterwards
being accepting and non judgemental of what about	appearing disinterested in what is spoken is spoken about
not talking about the supervisee outside	inadvertently disclosing to others about the session supervisee actions in handover time
being willing to apologise for making a mistake	

2) be willing to mutually learn from engaging in clinical supervision

In clinical supervision, the supervisor must be willing to learn from the supervisee and try to resist the temptation to be 'in charge' of the supervision session. A useful model to understand how the supervisor can learn as well as the supervisee, is to consider whether you demonstrate a need for learning (the incompetence element) and also raise awareness about the need to learn (the consciousness factor). O'Connor and Seymour (1993) describe four different stages of learning based on whether you consider yourself to be competent or not, and whether you are even aware of the need to learn.

Figure 2 shows how a supervisee can often come to the session with different levels of awareness and competence about what they recall in their stories about clinical practice. Part of the supervisory role is to try to make supervisee's more self 'conscious'

about their clinical practice by facilitating reflection on their practice in supervision. It is useful to remember that given the opportunity, supervisee's can also do the same for supervisory performance!

FIGURE 2:
DIFFERENT LEVELS OF PRACTICE AWARENESS AND POTENTIAL SUPERVISEE LEARNING IN CLINICAL SUPERVISION

UNCONSCIOUS

Unconsciously competent?	***Unconsciously incompetent?***
THE SUPERVISEE IS UNAWARE THAT HE DOES SOMETHING WELL IN PRACTICE	THE SUPERVISEE IS UNAWARE THAT HE DOES NOT KNOW SOMETHING IMPORTANT ABOUT PRACTICE
COMPETENT	**INCOMPETENT**
THE SUPERVISEE IS AWARE THAT HE DOES SOMETHING WELL IN PRACTICE BUT HAS TO CONTINUALLY WORK AT IT	THE SUPERVISEE IS AWARE THAT HE DOES NOT KNOW SOMETHING IMPORTANT ABOUT PRACTICE BUT IS WILLING TO IMPROVE
Consciously competent?	***Consciously incompetent?***

CONSCIOUS

3) be attentive to what is going on in the session

Being attentive to what goes on in the supervision session as a supervisor, is particularly important in relation to staff who seem blissfully ignorant of the consequences of inadequate practice. This incorporates the 'managerial' or 'accountability' domain of Proctor's (1986) model outlined earlier. One way of demonstrating that you are attentive to what is going on in supervision, is to listen properly.

Active listening means that a conscious effort needs to be made to not only listen to the words employed by the supervisee, but obtaining non verbal cues indicating any reaction to the situation being spoken about. Your own listening behaviours as a supervisor, can also be picked up by the supervisee, whilst they are talking and enhance, or limit, the supervisory conversation. Box 6 outlines some of the main differences between active and ordinary listening.

BOX 6:
DIFFERENCES IN SUPERVISOR BEHAVIOUR BETWEEN ACTIVELY LISTENING TO THE SUPERVISEE AND ORDINARY LISTENING:

Active listening	***Ordinary listening***
conscious effort made	unconscious effort made
little attention to what you hear to oneself	relating what you hear to oneself
attention to what is not being said	attention to what is intended to be heard
interest in verbal & non verbal communication	interest in verbal communication
unhurried approach to listening	constantly interrupting flow
body language demonstrates interest	listening whilst doing something else
maintains acceptable eye contact	easily distracted by external factors
encouraging interventions e.g . "Yes, Go on etc.	needing reminding of what has been said

Imagine what a supervisee would feel like if after having had difficulty in arranging clinical supervision, they arrive prepared, to be confronted with a supervisor who is appears disinterested, or preoccupied with something else. It is very unlikely the supervisee will wish to waste their precious time with that supervisor again. This aside from what the supervisee might disclose to others about your supervisory behaviour!

4) use effective questioning to help the supervisee notice them 'self' in clinical practice

The use of questioning in clinical supervision by the supervisor can limit or enhance the clinical supervision session. Ewles & Simnett (1999) distinguish between four main types of questions that are commonly used;

- closed questions that require short, factual, often one word answers
- open questions that offer more opportunity for fuller answers
- biased questions that indicate the questioner's preferable response
- multiple questions that contain more than one question

NOW DO TIME OUT 4:
Obtain a textbook of your choice that deals with interpersonal skills effectiveness, or ask permission to use an audio cassette within a clinical supervision session. Consider using written examples, how the use of questioning by the clinical supervisor might

limit, as well as enhance the clinical supervision session. What might be the implications for you as a clinical supervisor?

Remembering some of the responses to supervisee's questions can form the basis of giving feedback to the supervisee on elements of their clinical practice. In order for feedback to be effective in the session, the supervisor needs to ensure using their own questioning technique that they have fully understood what has been described or discussed.

5) be open to receive as well as give feedback on practice

Clinical supervisors have the primary responsibility of giving feedback to the supervisee. Clinical supervision feedback is different from the type of feedback you often give as a manager, or when you are assessing a student nurses' competencies to pass a placement area. Dolley et.al. (1998) suggest that constructive feedback in clinical supervision is best given like a sandwich, with the negative, in between two slices of positive! Some of the differences in giving feedback to a supervisee are illustrated in Box 7. As clinical supervision is only now beginning to emerge in practice, clinical supervisors also need to be open to receiving, as well as giving, critical comment on practice performance. Part of any contract should allow for regular review of both parties performance.

BOX 7:
WHAT SUPERVISORY FEEDBACK IS:

- Be responsible for personally owning, rather than generalising, the feedback given to the supervisee.
- The feedback statement needs to refer to observed, rather than assumed behaviours.
- Be specific about the behaviour you are giving feedback about, rather than something was 'good'.
- The behaviour referred to needs to be something that the supervisee is able to adapt, or change, rather than something that is not feasible.
- Give feedback as soon as possible after it has been heard or observed in the session.
- Encourage the supervisee to be specific about what he / she wants feedback on from the situations described.
- Ask for the supervisee to give you feedback on your own performance either in giving feedback or your behaviour with them in supervision.

WHAT SUPERVISORY FEEDBACK IS NOT:

- a punitive or disciplinary procedure
- insinuating that the supervisee practitioner is a failure
- criticism for the sake of it - "I have to find something wrong"
- manipulating the person into acting how you think they should act

- confusing to the supervisee
- a way of maintaining authority in the supervisory relationship
- an inaccurate account of what has gone on
- a blaming exercise to get the supervisee to change their practice

6) be able to summarise the content of the session with the supervisee

Part of the skill of the supervisor is to be able to summarise for the supervisee what has gone on in the session. For some supervisors this is negotiated with the supervisee by the use of audio visual aids, or simply a paper and a pencil in the early stages. It is helpful to validate your own summary of what has gone on in the session jointly with the supervisee.

Summarising the session does not require an over complex replay of the whole session, just touching on the main learning points that have been raised. If the supervisor has continually been giving feedback throughout the session, it is not necessary to cover all the main points in detail again. Key points for supervisors are to be alert to what is being said and the supervisee reaction to it. Of particular importance is validating this with the supervisee for accuracy. Included in any summary should be what the supervisee intentions or actions are likely to be as a result of the session.

EVALUATING CLINICAL SUPERVISION

Perhaps this final part of the article should have been the first, as monitoring the effectiveness of clinical supervision should be one of the initial things to consider in practice, rather than being tagged on as an optional extra at the end. But to begin clinical supervision with the 'end in mind' is extremely difficult, as the concept is not yet a feature of everyday nursing practice (Driscoll in print). Therefore any potential benefits or outcomes for practitioners and their patients understandably will be somewhat tentative.

NOW DO TIME OUT 5:
As a final exercise read over this article again and identify what points you consider important in supervisory practice. Using a maximum of one sheet of A4 paper, devise your own evaluative tool for monitoring the effectiveness of your supervisory performance. This could be developed in conjunction with your supervisees. At the very least, it would be interesting to compare what you as a clinical supervisor consider effective clinical supervision to be, with what your supervisee(s) consider it to be.

Clinical supervision offers a lifeline for concerned practitioners to safely explore, how the practice of nursing can be enhanced and be more effective. in clinical supervision is an important part of the implementation process, and will contribute to evaluating its effectiveness whether as an individual supervisee, or for your unit as a whole. Try to

think of the ‘end in mind’ by reflecting on, and documenting what effective clinical supervision looks like and comparing that to what actually happens in practice. In this way, clinical supervision then can really be said to be emerging from clinical practice and not just how others outside practice think it should be.

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

1) Which of the following is NOT recognised as a function of a clinical supervisor in practice?
a) facilitating reflection on practice
b) helping practitioners explore a disciplinary procedure
c) helping practitioners become more aware of their accountability in practice
d) formally disciplining practitioners
e) supporting practitioners to ensure quality clinical practice

2) Why might newer practitioners be more willing to accept clinical supervision than some of their traditional counterparts in practice?
a) because they are not as accountable
b) because it is seen as an extension of preceptoring and mentoring schemes
c) because they might be disciplined
d) because they are more assertive in practice

3) In what way can agreeing a contract beforehand assist with the uptake of clinical supervision?
a) it demonstrates to the line manager you are getting involved
b) it formalises clinical supervision
c) it ensures people will turn up for sessions
d) it helps to clarify what both can expect to happen in the session

4) Which in your opinion is NOT an issue for a clinical supervision contract?
a) how often meetings will take place
b) disclosures about how badly the unit is run
c) supervisee anxieties about the supervision process
d) how confidentiality will be maintained
e) what happens if neither party can get along with each other in a session

5) Clinical supervision can be helpful for supervisees because:
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

6) Clinical supervision can demoralise supervisees if the clinical supervisor:
a) challenges what is happening in clinical practice
b) constantly focusses on what went wrong in practice
c) makes the supervisee become more aware of their practice
d) clarifies what is being said
e) fails to make provision for some liquid refreshment

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

8) The main reason for a clinical supervisor actively listening to a supervisee is:
a) to not forget what was discussed
b) compile evidence of them not being a good practitioner
c) to keep the supervisee 'on their toes' during the session
d) demonstrate a genuine interest in what is being said
e) because it role models good mental health nurse practice

9) In your opinion what is NOT a way of offering feedback to a supervisee?
a) shaming the supervisee to change their practice
b) discussing feasible options about their clinical practice
c) being specific on what the supervisee has said
d) validating rather than assuming what has been said beforehand
e) asking the supervisee what they would like feedback on about the practice they have described

10) The main reason for evaluating clinical supervision is:
a) so the supervisee is not unhappy with the session
b) to monitor its effectiveness in practice
c) to keep in line with the organisational policy
d) to formally account for time spent during clinical practice
e) go towards evidence of maintaining professional registration

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

Hayley is a new clinical supervisor, although an experienced charge nurse specialising in acute mental health nursing. Although not having been involved in giving clinical supervision before, since completing supervisor training just over six months ago she has been in supervision herself for the last four months.
She is approached by Carly a staff nurse who has worked on an adjacent ward for clinical supervision. They have met once in which a supervision contract was agreed and are embarking on the second session in which Carly outlines personal anxieties about the disturbed behaviour of a patient / client of whom she is the key worker.

11) What do you consider might be the benefit for Carly discussing this patient / client in clinical supervision?
a) she could find out more about anxiety
b) she could find out more about clinical supervision
c) she could find have her practice problems solved
d) she could obtain some confidential professional support in dealing with disturbed patients / clients

12) What aspects of Carly's clinical care is Hayley unlikely to be concerned with?
a) the feelings she has about being a key worker for the patient / client
b) how she could minimise her responsibilities as a key worker
c) how she is currently managing the disturbed behaviour
d) the aspects of the disturbed behaviour that are causing anxiety
e) any previous experience Carly has in looking after such individuals in practice

13) What in your opinion is an inappropriate topic for the clinical supervisor to discuss with Carly?
a) guilty feelings about not being able to deal with the patient / client
b) reviewing the current care programme
c) how to avoid contact with the patient / client
d) positive aspects of dealing with disturbed behaviour previously
e) ways in which disturbed behaviour can affect all staff

14) Whilst talking about the situation, Carly discloses that she wishes she could run away from the session, Hayley replies that what could be going on is;
a) a parallel process
b) an embarrassing process
c) a nursing process
d) a reflective process

15) The clinical supervisor can help key working roles;
a) confronting staff with poor aspects of key working practice
b) because they are usually more senior in clinical practice
c) by exploring what concerns practitioners have about key working
d) because they often know what to do in situations
e) by giving the benefit of having more experience in practice

16) What in your opinion might be a barrier to Carly discussing her concerns about clinical practice in clinical supervision?
a) having a choice of clinical supervisor
b) having a clinical supervisor visit that is external to the unit
c) having been made aware of the supervisor talking about a previous supervision session to a practitioner in the coffee room
d) having had an opportunity to discuss boundaries in the first session of clinical supervision

17) At the end of the session Carly remarks that she now feels 'better', and it reminds her of how patients / clients react after a therapy session on the unit. Hayley explains that clinical supervision differs from therapy because;
a) not all supervisors are not psychotherapists
b) it does not have any therapeutic effects
c) the emphasis is on aspects of nursing practice
d) you do not have to pay for it

18) Hayley asks Carly whether she is going to write up what had gone in the session as it was important to:
a) practice writing for better care records
b) remind the supervisor what went on in the next session
c) to be more self aware of what was going on in practice
d) use a structured model for reflection
e) describe clinical practice

19) At the end of the session, Hayley questions Carly about her supervisory performance because:
a) she likes to be popular with staff members
b) she can also learn from the supervision process
c) to find out if she was any good in the session
d) she is a reflective practitioner
e) it helps her de'role'

20) What type of questioning about supervisory practice is likely to elicit the best response from Carly?
a) closed questioning
b) open questioning

c) biased questioning
d) multiple questioning

MULTIPLE CHOICE ASSESSMENT: GETTING THE MOST FROM CLINICAL SUPERVISION (2) : THE SUPERVISOR

ANSWER SHEET

1.
d) formally disciplining practitioners
clinical supervision is not part of the management process
2.
b) because it is seen as an extension of preceptoring and mentoring schemes
traditional practitioners are not often used to getting regular feedback on practice
3.
d) it helps to clarify what both can expect to happen in the session
both are new to the process and need to clarify each others roles and responsibilities as well as expectations
4.
b) disclosures about how badly the unit is run
contracting is not about whingeing or moaning about practice
5.
a) is an opportunity for getting formalised feedback on clinical practice
something that is not yet a regular feature in practice
6.
b) constantly focusses on what went wrong in practice
self evident and often a regular feature in clinical practice leading to avoidance
7.
e) telling the supervisee to only give positive feedback to you
defeats the object of clinical supervision
8.
d) demonstrate a genuine interest in what is being said
without this basic attribute clinical supervision will be pointless
9.
a) shaming the supervisee to change their practice
forget the supervisee ever coming back to a session otherwise!
10.
b) to monitor its effectiveness in practice
this is essential for its continuance in practice as it has to compete with all the other important things that happen in practice

MULTIPLE CHOICE ASSESSMENT: GETTING THE MOST FROM CLINICAL SUPERVISION(2) : THE SUPERVISOR

ANSWER SHEET

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11.

d) she could obtain some confidential professional support in dealing with disturbed patients / clients

these are essential elements of clinical supervision

12.

b) how she could minimise her responsibilities as a key worker

clinical supervision is not an excuse for reducing accountability in practice

13.

c) how to avoid contact with the patient / client

clinical supervision should confront difficult clinical practice that is disclosed, not help the supervisee avoid the issues raised by it

14.

a) a parallel process

a specific supervisory technique

15.

c) by exploring what concerns practitioners have about key working

clinical supervision is intended to be an enabling rather than punitive process about practice

16.

c) 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

17.

c) the emphasis is on aspects of nursing practice

clinical supervision is practice focussed

18.

c) to be more self aware of what was going on in practice

reflective writing increases self awareness

19) At the end of the session, Hayley questions Carly about her supervisory performance because:

b) she can also learn from the supervision process
the supervisors role is not to 'be in charge' but open enough as the supervisee is to obtain feedback on in this case supervisory performance
20.
b) open questioning
this type of questioning encourages the other to elaborate more on what is being asked