



Clinical Supervision for Advanced Practice Nurses

Information for Clinical Supervisors and Supervisees

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Clinical Supervision for Advanced Practice Nurses

Information for Clinical Supervisors and Supervisees

Clinical supervision is a formal process of professional support and learning between two or more practitioners within a safe and supportive environment that enables a continuum of reflective critical analysis of care to ensure quality patient services and the wellbeing of the practitioner (Bishop, 2007; Department of Health, 1993).

Supervision is provided through regular, time protected, facilitated sessions during which practitioners reflect on complex issues which impact and influence their practice (Bond & Holland, 2010). This reflection is facilitated by experienced colleagues who have training and expertise in facilitation.

The purpose of this module is to prepare Advanced Practice Nurse Practitioners to be capable and skilled supervisors able to effectively support and enable the development of professional skills and clinical autonomy of supervisees.

Practitioners who complete this module will:

- Demonstrate an understanding of the process of clinical supervision
- Describe the benefits of a clinical supervision process for Advanced Practice Nurses
- Describe specific skills of clinical supervision
- Demonstrate an understanding of skills that support group supervision
- Commit to providing clinical supervision to a group of Advanced Practice Nurses
- Participate in ongoing professional development opportunities for clinical supervisors.

1. The RCH Model for Clinical Supervision

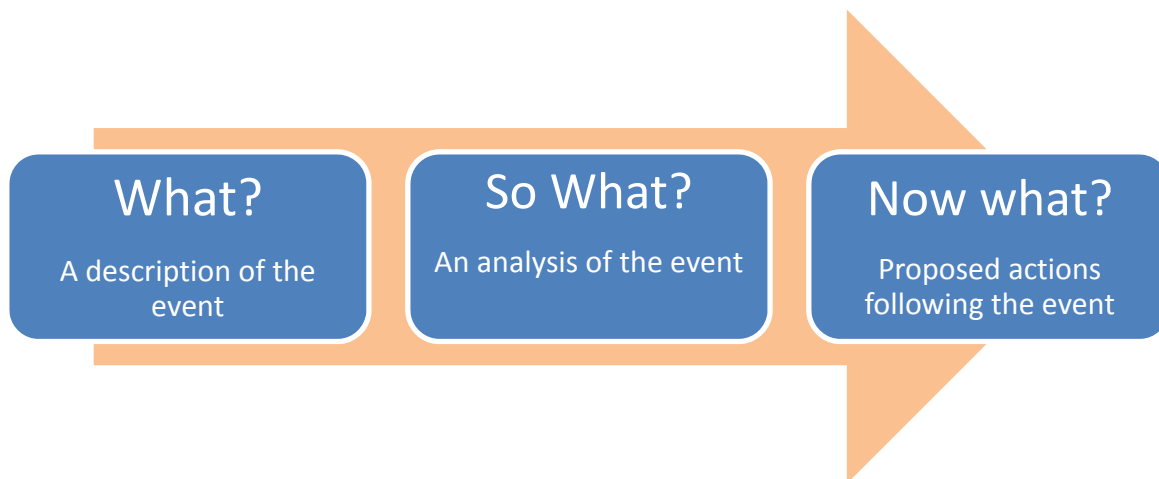
The clinical supervision process for Advanced Practice Nurses at the Royal Children's Hospital, Melbourne is based on an experiential learning framework: Driscoll Reflective Model for clinical supervision (Lynch et al, 2008). Reflective models provide a forum for intentional reflection on practice. The aim of reflective practice is that nurses will "learn from their reflections, revise their conceptual perspectives and act differently in the future as a result." (Daley, et al, 2004, p279 as

cited by Lynch et al 2008).

Driscoll (2000 as cited by Lynch et al, 2008) defines clinical supervision as a process of guided reflection where the supervisor supports and guides the supervisee(s) through the process.

Driscoll's model consists of three components which each identify different stages in the process of the reflective cycle.

Figure 1. Driscoll's "What" Model for Reflective Practice



Movement through each stage of the model is supported by the use of trigger questions. Supervisors assist supervisee(s) to engage in a process of reflection by using focussed, timely trigger questions.

Examples of trigger questions for each stage as described by Lynch et al (2008):

What?

- Actually happened?
- Did you see/do and what was your reaction to the event?
- Did other people who were involved in this event do?
- Is the purpose on reflecting on this particular event?

So What?

- Did I feel at the time?
- Were my feelings like compared to others?
- Are my feelings now after the event?

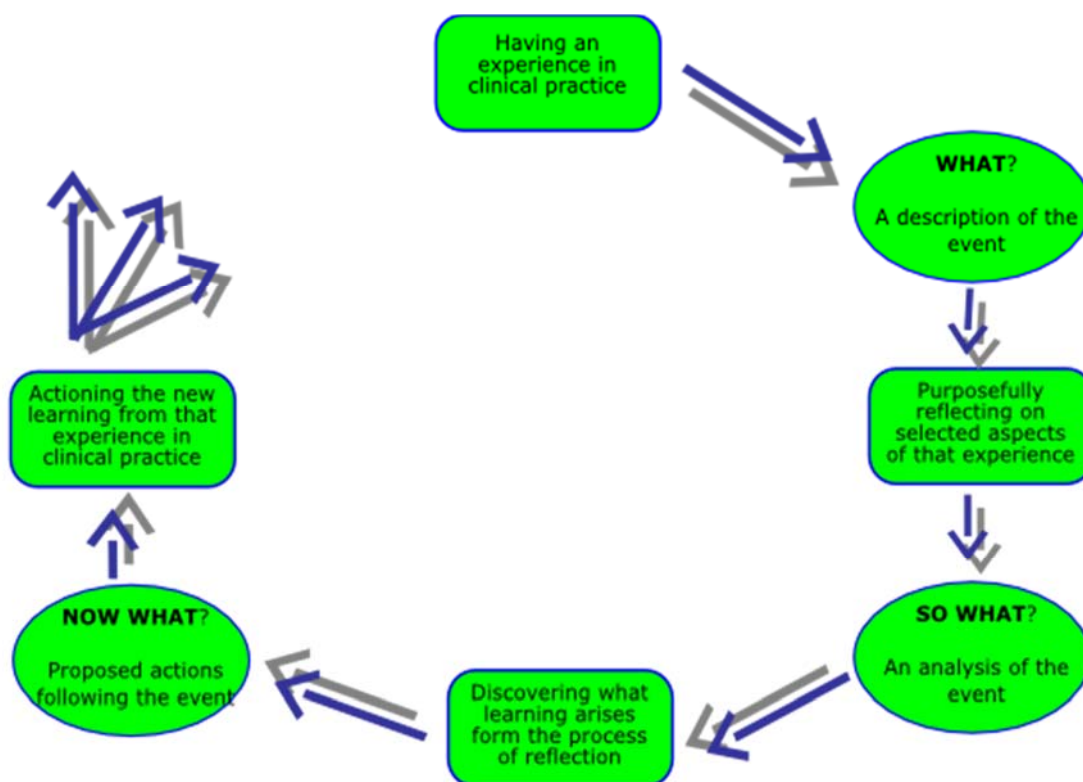
Now What?

- Are the implications for me and others in the situation?
- Difference does it make if I choose to do nothing?
- Can I do to modify my practice if this situation arises again?

Following completing of the 'Now what' section, the supervisor and supervisee(s) reflect on the event and the discussion and a plan is formulated to action the new learning. At the next session, discussion centres on the result of the action plan (Lynch et al, 2008).

Figure 2 is a diagrammatic representation of the entire process as described by Driscoll (http://www.nottingham.ac.uk/nmp/sonet/rlos/placs/critical_reflection/models/driscoll_cycle.html).

Figure 2: Driscoll Reflective Practice Process



Taken from Driscoll (2007), p.44



To gain a greater understanding of the process of clinical supervision and distinguish clinical supervision from other formal relationships, read

Appendix 1: Chapter 1: An introduction to clinical supervision. pp1-26.

Lynch, L., Hancox, K., Happell, B. & Parker, J. (2008). *Clinical Supervision for Nurses*. West Sussex: Wiley-Blackwell.



Reflective exercise:

Make a list of words that describe clinical supervision.

List similarities and differences between clinical supervision and other formal professional relationships you have experienced.

2. Benefits of Clinical Supervision for Advanced Practice Nurses

Nursing, as a practice based profession, has a commitment to the ongoing development and improvement of clinical practice in order to ensure patients and their families consistently receive the highest standards of care and treatment (Lynch et al, 2008). Practice development is described as the process where outcomes gained through professional development activities are translated into practice and result in improved health outcomes. Clinical supervision forms an integral part of practice development as it encourages nurses to focus on practice issues and therefore can be the impetus for change (Lynch et al, 2008). In addition to having an impact on practice, clinical supervision can encourage nurses to take responsibility for their practice, develop creativity, lateral thinking and political awareness, improve relationships with managers and become effective modellers of best practice (Lynch et al, 2008). Clinical supervision is crucial for Advanced Practice Nurses in leadership roles as it fosters individual professional growth in a supportive environment.



Reflective exercise:

What do you see as the main benefits of participating in clinical supervision?

3. The clinical supervision relationship

The effectiveness of clinical supervision is a direct result of the quality of the clinical supervision relationship (Bond & Holland, 2010). Achieving a quality relationship is predominantly reliant on the skill and expertise of the supervisor. For this reason, it is imperative that supervisors receive appropriate theoretical and practical preparation (Lynch et al, 2008). The role of the supervisee is also important in order to build the relationship and gain the most out of the experience. It is important, therefore, that all participants have a good understanding of the supervision process and the clinical supervision relationship develops into an effective working alliance (Bond & Holland, 2010).

It is important that clinical supervisors volunteer and commit to the process and demonstrate well developed interpersonal skills. Lynch et al (2008) describe the ability to be warm, friendly, engaging, insightful, self-reflective and to respectfully challenge or question without seeming critical as important interpersonal skills. Supervisors also need to be highly skilled communicators who have the ability to actively listen, clarify and summarise issues. Clinical supervisors must demonstrate a good understanding of and be able to articulate the model of clinical supervision in use in order to assist supervisees to gain maximum benefit from the process.

The negotiation of a clinical supervision contract involves an awareness of the supervisee and supervisor's expectations of each other and agreed boundaries (Bond & Holland, 2010). When both parties enter into an agreement about how they will work together in clinical supervision, expectations of each other are clarified, trust is built and exploration of sensitive material can occur in a secure frame. Both parties have rights and responsibilities. Clinical supervisors need to have an awareness of the rights of the supervisee in order to promote an empowered relationship.

Supervisee's rights and responsibilities: (Adapted from Bond & Holland, 2010)

A supervisee has the right to:

- Some choice of supervisor

- Choice of topic
- To be treated with respect as an equal partner in the clinical supervision relationship
- Confidentiality
- Protected time and space for clinical supervision sessions
- Talk about feelings and uncertainties

A supervisee is responsible for:

- Own learning and development
- Negotiating decisions about clinical supervision
- Preparing for sessions by identifying issues to reflect upon
- Attending sessions punctually, giving them a high priority
- Being open to challenge
- Giving feedback to the clinical supervisor about their facilitation
- Staying on task during sessions
- Self-disclosure
- Keeping attendance records
- Being accountable for own actions

Supervisors also have rights and responsibilities within the supervision relationship. Taking a facilitative, empowering role does not mean that supervisors must give up their own personal power (Bond & Holland, 2010).

A Supervisor has the right to: (Adapted from Bond & Holland, 2010)

- To be treated with respect as an equal partner in the clinical supervision relationship
- Break confidentiality in exceptional circumstances
- Challenge any behaviours or values about the supervisee's practice which are concerning or incongruent with the values of the organisation
- Challenge any behaviour which is insulting or rude
- Set personal and professional boundaries on what issues you listen to
- Choose whether to work with an individual as their supervisor

A Supervisor is responsible for:

- Preparing for the clinical supervision session
- Being reliable and honouring agreed appointments
- Confidentiality except for issues around unsafe practice
- Avoiding any line management or assessment role from being part of the clinical

supervision session

- Responding humanely for distressing issues
- Encourage the supervisee to seek specialist help for personal problems where necessary
- Challenge any behaviours which give you concerns about a supervisee's practice
- Ensure you have your own clinical supervision and support systems
- Keep records of attendance, not content of sessions

4. In-depth reflection skills for Supervisees

Choosing a topic to take to clinical supervision

Supervisee's need to give some thought to their agenda for the clinical supervision session prior to the session. This will assist the supervisee to make the transition from action-orientated work to in-depth reflection (Bond & Holland, 2010). Sometimes topics for reflection will be obvious to the supervisee and other times it may be difficult to think of a suitable topic. Bond & Holland (2010) suggest that considering each of these 4 main areas may assist in pinpointing topics for reflection:

Particular patient / client /family: consider care, relationship, care planning, nursing procedures, communication about care plans/progress, health education, evaluation of care, discharge planning.

Other responsibilities apart from direct patient care: caseload management, being a team member, time management, management of junior staff, liaison with other professionals, record keeping, training other staff.

Stress of work or affecting work: exploration of some of the stresses or pressures arising from the role or stressors that occur outside work which have an influence on your work.

Your development: consider which personal qualities or types of professional expertise are being utilised or developed within your work or which you would like to develop more in the future.

Models for reflection

Bond and Holland (2010) describe a number of reflection structures that may be helpful for clinicians to make the transition from activity to reflection. It may be that one approach resonates more strongly with you. Some clinicians will be more suited to an intuitive approach while others may find that they are attracted to a logical approach. Each of the reflection methods described by Bond and Holland (2010) are summarised below.

Intuitive methods of reflection

Experienced nurses internalise their knowledge and their expertise, according to Bond & Holland (2010) and their work is influenced by their informed intuition. Benner's (1984) seminal work also explores this phenomenon that intuition is an importance component of expert nursing practice.

Intuitive thinking can be a useful skill when the issue is not clearly defined and information about the situation is incomplete. Often goals are not clear, outcomes are not precise and easily predicted. This approach to reflection can be helpful when reflecting on complex situations involving emotions and interpersonal relationships. Logical thinking, on its own, is more useful and satisfying when the issue is more straightforward with goals and outcomes easily identified. Bond & Holland (2010) argue that most of the issues brought to clinical

supervision involve relationships with colleagues, managers, clients / families and applying a purely logical framework to think through these issues would often be an ineffective exercise.

Figure 3 is a summary of intuitive reflection methods as outlined by Bond & Holland (2010, p132)

Figure 3: Intuitive Methods of Reflection

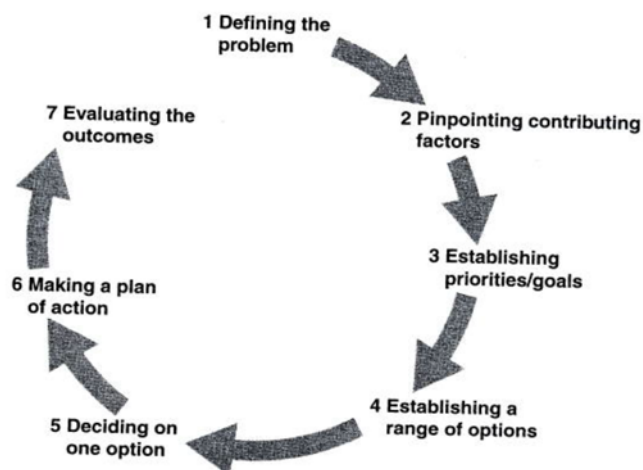
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- **TOP-OF-THE-HEAD REFLECTION** – Start talking or writing, without censoring; look back and pick out themes, significant points, gaps, steps in reflection so far
 - **FREE-FALL WRITING** – Write a ‘stem’ phrase at the top of a blank sheet; write anything, that comes into your mind, without censoring; stop at the end of time limit and look back; highlight one especially loaded phrase and write that at the top of another sheet as a new ‘stem’ phrase; continue; look back over your sheets and pick out any themes
 - **BRAINSTORMING** – Write a specific question; within a time limit, list any ideas without censoring; rest; continue brainstorming for a further, shorter time limit; look back over all the ideas and cross out those which are totally out of the question; consider the others
 - **SLEEPING ON IT** – Go to sleep at night thinking ‘I wonder such and such’ and note any insights when you wake
 - **SHORT RELAXATION BREAK** – Use physical relaxation techniques, ‘time out’ break to walk around or daydream or silence during the clinical supervision session, in order to allow intuitive thoughts to pop up
 - **DRAWING THE ISSUE** – Ponder silently about the issue that you have identified; begin to draw freely in an abstract way, covering the paper; sit back and reflect on what you have drawn
 - **MIND MAPPING** – Write a main heading; write the thoughts this heading stimulates, in a circle around the central point, linking each to the central heading with a line; expand on each of the thoughts by adding key words related to each one, in a little cluster around it; sit back and look at the overall map, noticing links
-

Logical frameworks for reflection

Problem solving frameworks

A problem solving spiral is useful when there are likely to be one or a small number of courses of action. Figure 4 shows the step by step approach to working through a problem. The questions in Figure 6 may assist supervisees to work their way through the spiral. It is important to work through the entire process and not skip straight to deciding on one option after defining the problem.

Figure 4: A problem solving spiral (Bond & Holland, 2010, p137)



Force field analysis

The force field analysis model was first described by Lewin (1951, as cited by Bond and Holland, 2010). It is a well utilised and tested model that is suited for dealing with a multifaceted problem for which there is no single solution. Bond and Holland (2010) suggest that is a useful framework for analysing complex issues where solutions are not immediately obvious. Figure 5 outlines the format for working through each step.

Step 4 Driving forces	Step 1 Frozen position	Step 3 Restraining forces	Step 2 Vision
List here	Describe here	List here	Describe here
1		1	
2		2	
3		3	
4		4	
5		5	
6		6	
7		7	
8		8	
Step 6 Plan steps to enhance the power of each driving force		Step 5 Plan steps to reduce the power of each restraining force	




Figure 5: Force Field Analysis Chart (Bond & Holland, 2010, p140)

Bond and Holland (2010, p139) provide a list of questions that can assist supervisees to work through each stage of problem solving frameworks (Figure 6).

Figure 6: Questions to prompt in depth reflection in problem solving frameworks

<p>1. Defining the problem</p> <ul style="list-style-type: none"> • What's bothering you? • What exactly is the problem? <p>2. Pinpointing contributing factors</p> <ul style="list-style-type: none"> • What do you think contributes to this problem or difficulty? • How do you think you contribute to the problem? • What's behind the problem? • Think of a time when this problem did not exist. What was different about the situation then? • Which of these factors do you think should be tackled first? • Do you need to redefine the problem or are you clear about what exactly the problem is? <p>3. Establishing priorities/goals</p> <ul style="list-style-type: none"> • What are you hoping to achieve? • What are you hoping for/aiming at in the long run? • Imagine that it is now, say, six months later and this problem has been dealt with. What's different now? • What are your ultimate goals? • What short-term goals would help towards that end? • Are your goals realistic? If not, what would be more realistic? <p>4. Establishing a range of options</p> <ul style="list-style-type: none"> • What solutions have you tried already? • What options have you thought of so far? • Allowing your ideas to flow freely, what ways can you think of to achieve your goals? Brainstorm and don't censor, just let anything, however crazy, come into your mind 	<ul style="list-style-type: none"> • What's the most outrageous or extreme course of action that comes to mind? What's the most extreme form of inaction? Putting these two extremes at each end of a continuum, what options are there in between? Cross out anything which you are definitely not prepared to do under any circumstances whatsoever <p>5. Deciding on one option</p> <ul style="list-style-type: none"> • Which is likely to be the most effective course of action, bearing in mind your goals? • Given that all your options are going to be difficult, which is the least worst? <p>6. Making a plan of action</p> <ul style="list-style-type: none"> • What's your plan? • What is your very first step? • Then what next? • Whose help do you need? • When exactly are you going to do these things? • How will you keep up your courage and resolve to carry out this plan? • How will you know if you have been successful? • When exactly will you evaluate the outcome? <p>7. (Later) Evaluating your decision</p> <ul style="list-style-type: none"> • How far were your goals achieved? • In the light of further information or events, what, if anything, needs to be done next? • Looking back at the factors contributing to the initial problem, is there anything else which could usefully be tackled?
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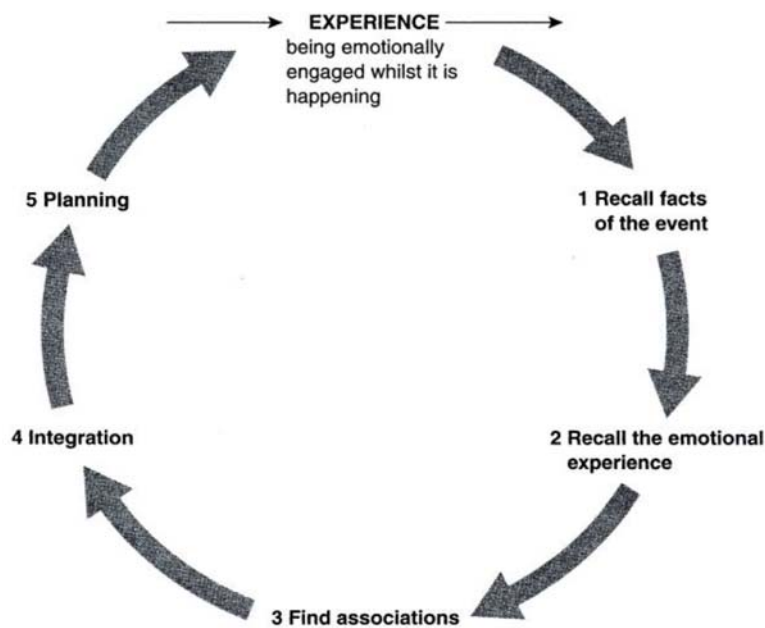
Experiential learning cycles

The process from learning from experience is known as the experiential learning cycle and was first described by Kolb (1984, as cited by Bond & Holland, 2010). All experimental learning cycles consist of three core stages: 'What?', 'So What?' and 'Now What?' (Figure 2). It is important to be fully engaged and actively participating in the experience, in order to facilitate the deepest learning. It is also imperative that supervisees devote time to fully analysing emerging insights in the emotional dimension to find meaning and the learning points (Bond & Holland, 2010) rather than bypassing the in-depth reflection required to discover the significance of the experience.

Emotional skills learning cycle

The emotional skills development framework assists supervisees to reflect on their abilities to utilise emotional energy. It focusses on recalling the emotional experience, finding patterns or associations and formulating a plan to address these conclusions (Figure 7).

Figure 7: Emotional Skills Cycle (Bond & Holland, 2010, p 147).

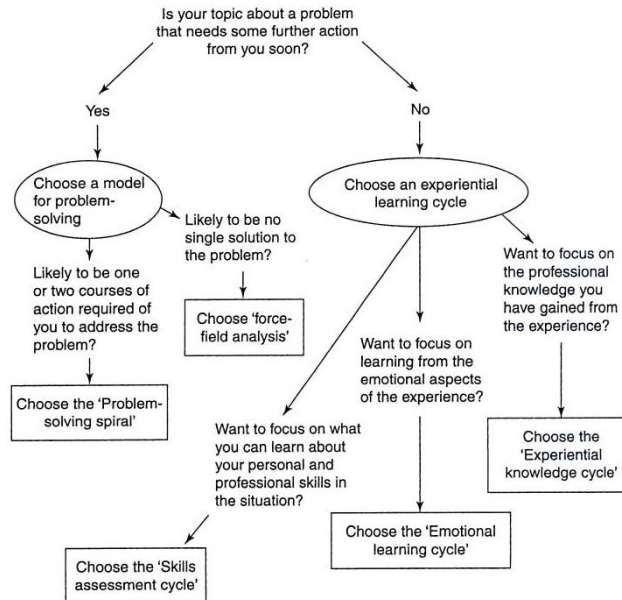


Emotional competence is an important skill for nurses as the essential skills of awareness and self-acceptance enable individuals to calm and settle themselves through containment, switching and contemplation (Bond & Holland, 2010).

It is important to understand each of the frameworks and utilise those that resonate the most when reflecting on your clinical practice and choosing a topic for the clinical supervision session. As you become more familiar with the different frameworks, you will be able to choose the most appropriate framework for the issue that you wish to explore. Bond and Holland (2010) recommend that supervisees become familiar with at least two different frameworks, one problem-solving and one experiential learning cycle and use a simplified version of each initially. Problem solving frameworks are best for current problems where further action is required. If the issue is from the past, and reflection on the learnings is the major goal, an experiential framework is most suitable. Once the supervisee becomes skilled at using these frameworks, they can combine them for maximum effectiveness.

Bond and Holland (2010, 136) provide the following diagram summarising the decision tree for choosing a logical model for reflection.

Figure 8: Decision tree for logical reflection.



Stages in developing in-depth reflection skills

Supervisees will develop through experience greater skills in building and deepening their skills in reflective practice. Over time, the 'So What?' phase of the experiential learning cycle will deepen and one's ability to put in practice the learnings will increase. Supervisees will develop the ability to see multiple perspectives, i.e. from their own perspective, from the client and also from the workplace. As supervisees experience the process of clinical supervision, their reflective and analytical skills increase moving from a focus on specific incidents to a reflection of one's own skills, perceptions and understanding of the impact on the client. Bond and Holland demonstrate this growth in Figure 9.

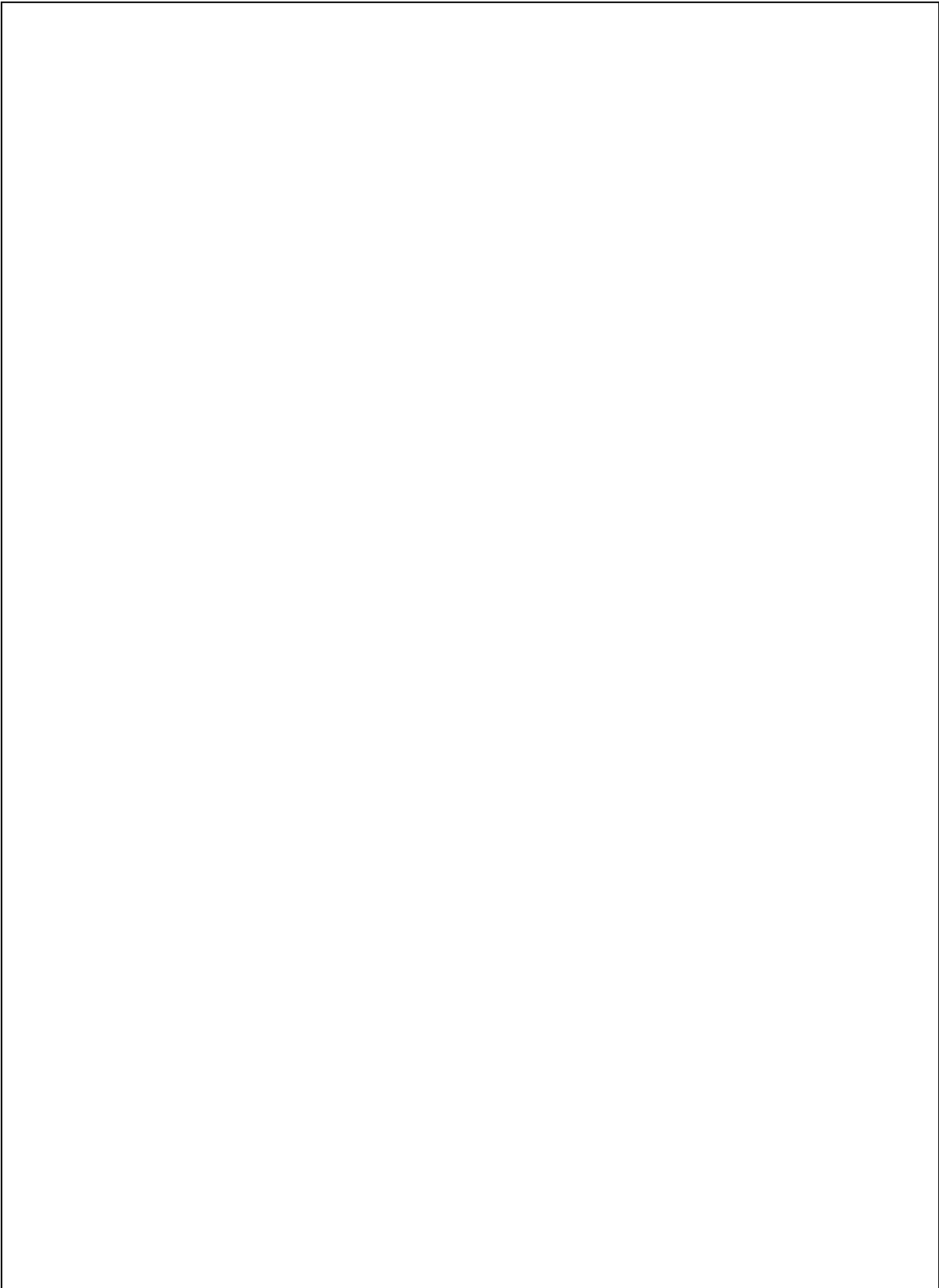
Figure 9: Developmental stages in using clinical supervision as a supervisee.

Level 1	Level 2	Level 3	Level 4
<p><i>Focus:</i> Problem-centred</p> <p><i>Key question:</i> 'Am I doing the right thing?' 'What do I do next?'</p>	<p>(Includes Level 1)</p> <p><i>Focus:</i> Client/patient centred</p> <p><i>Key question:</i> 'How is the client/patient developing?'</p>	<p>(Includes Level 1)</p> <p>(Includes Level 2)</p> <p><i>Focus:</i> Relationship with client/patient</p> <p><i>Key question:</i> 'How am I and the client/patient relating and what's my part in that?'</p>	<p>(Includes Level 1)</p> <p>(Includes Level 2)</p> <p>(Includes Level 3)</p> <p><i>Focus:</i> Developing the 'internal supervisor'</p> <p><i>Key question:</i> 'What's happening now in this situation that parallels what happens in my practice while I'm working with the client?'</p>
Level 1	Level 2	Level 3	Level 4



Reflective exercise:

Reflect on your recent clinical practice experience and choose a topic that could be examined in a clinical supervision session. Use one of the reflective frameworks described above to prompt in-depth reflection in order to define the problem, identify contributing factors, identify goals and establish a plan of action.



5. Facilitation skills for Supervisors

Clinical supervisors have an important role in encouraging exploratory dialogue and a space for reflection so that the supervisee can expand their personal and professional knowledge, their logical and analytical thinking abilities, their emotional awareness, self-esteem, intuition, advocacy for

themselves, their clients and colleagues and their beliefs about what is important (Bond & Holland, 2010). Effective facilitation enables the supervisee to develop insights and formulate plans based on their own decision.

It is important that supervisors understand the concept of facilitation, that is ‘to supportively enable another person or group of people to decide, do or learn something for themselves’ (Bond & Holland, 2010, p156). Effective facilitation involves supervisors utilising **support, catalytic, challenging and informative skills** to facilitate mutual enquiry into complex clinical practice issues (Bond & Holland, 2010). Clinical supervisors need to achieve an appropriate balance by using predominantly the non-directive (supportive and catalytic) interventions in clinical supervision. The more directive interventions (challenging and informative) should be utilised less frequently (Bond & Holland, 2010).

Support skills of the clinical supervisor

Clinical supervisors need to adopt an approach to clinical supervision that is fundamentally supportive at all times. Support should be shown openly and explicitly and demonstrate authenticity by active listening and expressing support as a reaction to what is heard (Bond & Holland, 2010). Bond and Holland (2010, p161) outline ten ways of showing support (Figure 10).

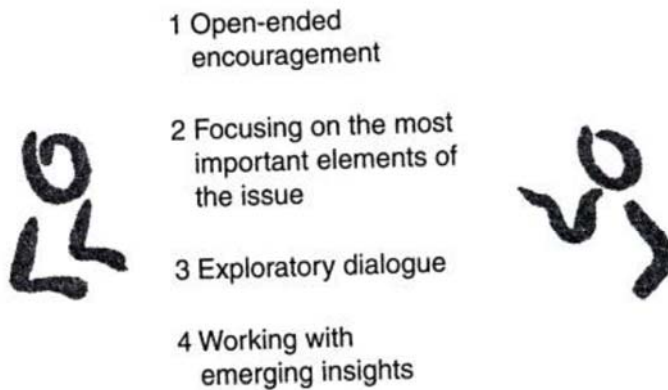
Figure 10: Ways of showing support in clinical supervision

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- **RELIABILITY AND PUNCTUALITY** – Making appointments with supervisee a priority; being punctual and sticking to time boundaries
 - **SETTLING** – Enabling the supervisee to settle, relax and put their journey to the session behind them (you need to be composed, settled and relaxed yourself first!)
 - **SHOWING YOU ARE LISTENING WITH ACCEPTANCE** – Paying attention to the supervisee as a human being and seeking to understand the supervisee’s perception of the situation they are describing; showing you are listening by your non-verbal responses and by summarizing their viewpoint, respecting it as their perspective
 - **ENCOURAGEMENT** – Showing interest, pointing out strengths or achievements that the supervisee has shown, encourage the supervisee to talk positively about herself
 - **TUNING IN** – Tuning in to the emotions being expressed or which are implicit and tuning in to their level of intensity; putting into words and acknowledging the level of emotion that underlies what supervisee is saying; tentatively to allow supervisee to find their own words for their feelings; accepting of the emotion, non-critical
 - **ADVOCACY** – Indicating when the supervisee deserves better, perhaps more consideration, information, respect for personal or professional rights, support, etc.
 - **SUPPORTIVE SILENCE** – Space to reflect
 - **EMOTIONAL FIRST AID** – Supporting emotional release without making a fuss; showing your acceptance; enabling emotional recovery
 - **SELF-DISCLOSURE** – Sharing a little of your own experience or feelings; expressing any caring and concerned feelings you have about the supervisee
 - **APOLOGIZING** – For any of your mistakes, without defensiveness
-

Catalytic skills of the clinical supervisor

The use of catalytic skills in clinical supervision enables the supervisee to reflect deeply on an experience and move towards clearer learning outcomes without the supervisor contributing their own solutions (Bond & Holland, 2010). Clinical supervisors who use catalytic interventions demonstrate that they are listening and trying to understand. Bond and Holland (2010, p169) argue that catalytic skills are used in phases (Figure 11).

Figure 11: Phases in using catalytic skills



It is important to understand when catalytic skills are best utilised. Catalytic skills do not offer information, advice or challenge however they can lead a supervisee in a certain direction if consideration of the purpose of the strategies does not occur. Bond and Holland (2010, p170-5) outline four main reasons for using catalytic skills (Figures 12-15).

Figure 12: Catalytic skills phase 1: Open-ended encouragement to speak

-
- Support skills
 - Prompts to continue: non-verbal encouragement, e.g. nods, 'uh huh', 'hm'; verbal prompts, e.g. 'yes', 'really?', 'go on', 'and so ...?', 'and then ...?'
 - Echoing the last word or phrase
 - Very open questions, e.g. 'What would you like to talk about today?', 'What else would you like to say about that?', 'What do you think/feel about that?'
-

Figure 13: Catalytic skills phase 2: Focussing on the most important elements of the narrative

-
- Selective echoing: echo a significant word or phrase
 - Selective summary: pick out the aspects that seem important. Express this tentatively
 - Closed questions: questions that could be answered by a brief factual reply or 'yes' or 'no' to help supervisee focus on one aspect
 - Invite self-summary: ask supervisee to pick out the main points for themselves
-

Figure 14: Catalytic skills phase 3: Exploratory dialogue

-
- Logical prompts to analyse the experience, using problem-solving or reflective models and 'logical building' to point in which direction the supervisee seems to be going
 - Engaging imagination, such as Socratic questioning, encouragement to draw
 - Intuitive exploration, emphasizing wondering, mulling over, pondering, musing, sensing, speculating, hunches, e.g. "I wonder..."; 'I've been mulling over what you said about...'
 - 'Emotional barometer': aware of possibility absorbing and reflecting supervisee's suppressed feelings
 - Acknowledging the unknown
 - Identifying parallel processes
-

Figure 15: Catalytic skills phase 4: Working with emerging insights

-
- Enable recognition of insights – listen, remember, remind
 - Time to assimilate insights – invite supervisee to explore their significance
 - Allow the emerging plan to flow. Enable movement towards planning how to apply the insights to professional practice, focussed questions about specifics of the plan, 'what?, how?, with whose help?. when?' etc.
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Informative skills of the clinical supervisor

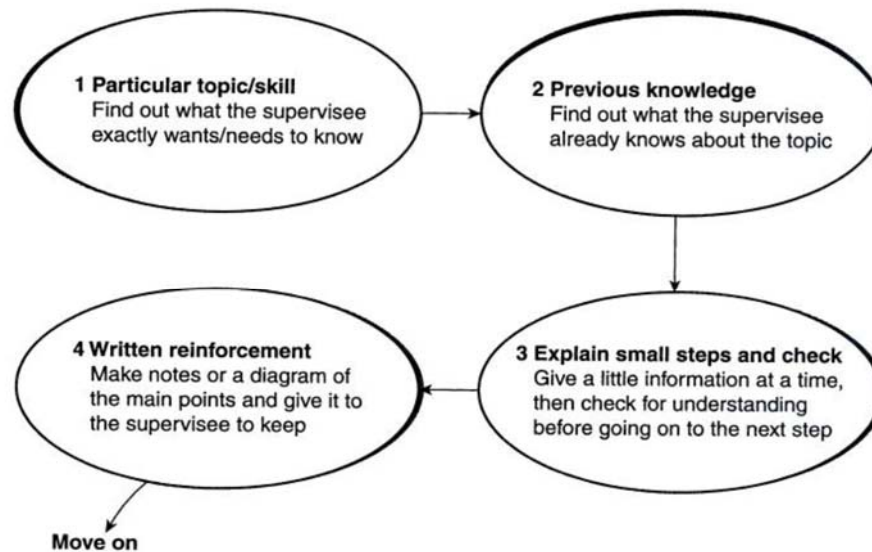
Giving information is sharing facts, opinions and procedures to assist the supervisee to make an informed decision about the most appropriate course of action to take. Bond and Holland (2010) are careful to distinguish that it is not giving advice. The emphasis needs to be on the supervisee making the decision on the action plan.

In some situations, giving information may be appropriate:

- The supervisee is stuck in their thinking
- The supervisee does not understand key facts or options
- The supervisee's gaps in knowledge are part of the issue
- The situation is critical and requires immediate action
- The supervisee has decided to take action that is inappropriate
- The supervisee is stuck in a cycle of behaviour that is destructive and supportive and catalytic strategies have not worked (Bond & Holland, 2010, p184).

Figure 16 demonstrates the steps in giving information as described by Bond & Holland, 2010, p185)

Figure 16: Steps in providing information



Challenging skills of the clinical supervisor

The purpose of challenging the supervisee is to make them aware of behaviour that is or potentially can contribute to the issue in question.

There are three conditions that support the use of challenging skills (Bond & Holland (2010):

1. Information is gained during the clinical supervision sessions only. If the information concerns or alarms the supervisor, they have the right to challenge the supervisee.
2. The supervisee is not aware of the problem. The supervisee may not have insight into the effects of their negative behaviour.
3. Supportive and catalytic strategies have been employed first but have not succeeded in raising awareness.

Bond and Holland (2010, p192) outline the following topic areas for challenging the supervisee:

- Inconsistencies
- Mistakes
- Avoiding responsibility
- Unsafe practice not being dealt with
- Mental blocks
- Misuse of clinical supervision time
- Avoiding awkward topics in the clinical supervision relationship
- Signs of an unacknowledged problem
- Prejudices and unfounded assumptions

Challenging skills have been described as the most difficult of the enabling skills to use. Utilising of the framework (Figure 16) will assist supervisors to learn and practice the skill. It is important for supervisors to acknowledge that supervisees should have enough professional resilience to manage the discomfort of being challenged within a safe space (Bond & Holland, 2010).



Reflective exercise:

Consider this clinical supervision example:

Violet is an APN working within the Department of Endocrinology and Diabetes as a Diabetes Nurse Educator. It is a very busy department and a number of Diabetes Nurse Educators in the team have recently left the organisation. As a result of this, Violet's workload has increased substantially. Violet regularly attends group clinical supervision.

Violet (in clinical supervision): My workload is becoming very difficult to management. Patient and family contacts are growing and demands from medical staff, research staff and requests for diabetes education from the wards are increasing. I feel pressured and I just know how I will manage to cope if this continues. There is so much pressure on me and they say they understand, but they just don't understand! Something has to give; it's like a powder keg waiting to explode. How can they expect a quality diabetes service when I am expected to work under these stressful conditions?

Consider that you are the clinical supervisor for the above case. How could you effectively facilitate discussion in this situation? Outline the types of supportive, catalytic, challenging and informative questions / interventions you could use to encourage exploratory dialogue and a space for reflection.

6. Group supervision

Group supervision is an advanced form of clinical supervision (Bond & Holland, 2010). Groups that are committed to the process and meet regularly experience intense support, greater stimulation, challenge and reflection. Members can learn a lot from the in-depth reflection of others. For group clinical supervision to be most effective, all members of the group need to have mastered the skills of supervisee, supervisor and group participant. It is important that facilitators have well developed skills in group facilitation (Bond & Holland, 2010).

Group supervision is defined by Bond & Holland (2010, p212) as the situation where “three or more people form a fixed membership group and have planned, regular meetings in which each person does in-depth reflection on complex issues relevant to their own practice and on the part they as individuals play in the quality of that practice, facilitated in that reflection by the other group members who cooperate as joint clinical supervisors.”

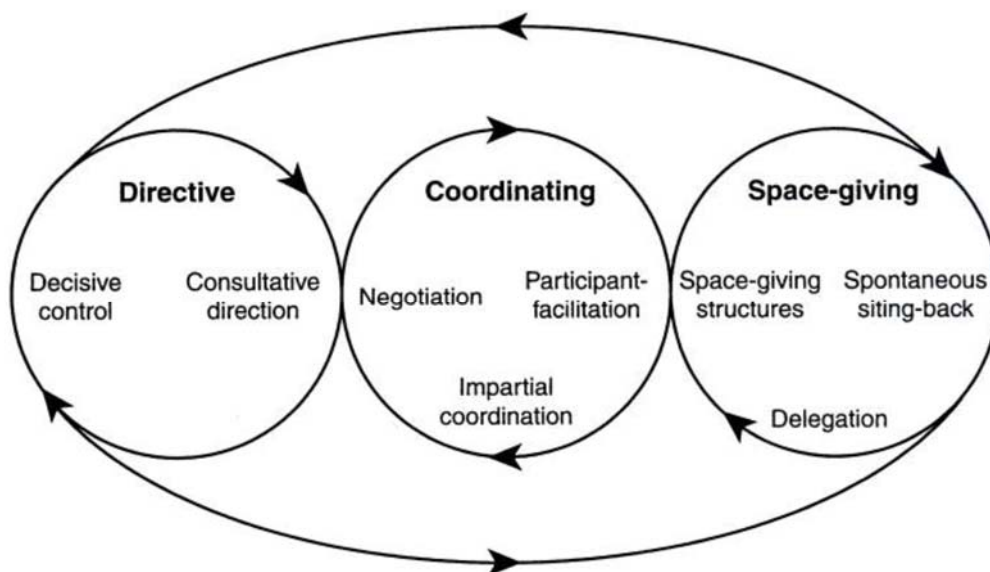
In addition to having well developed skills as a supervisee and supervisor, members of group supervision must also be skilled group participants (Bond & Holland, 2010). Effective group participants demonstrate skills of awareness, acceptance and impulse containment.

Group facilitators are responsible for managing the tasks and process of the group. Heron’s model (2001 as cited by Bond & Holland, 2010) suggests there are three options facilitators can choose when enabling the group to move forward:

1. To be directive and take charge of some of the tasks on behalf of the group.
2. To coordinate and manage some of the tasks within the group.
3. To give space and allow the group to manage tasks for themselves.

Facilitators can move from mode to mode from moment to moment (Bond & Holland, 2010, p220)

Figure 17: Flowing between the three modes of group supervision (Bond & Holland, 2010, p220)



Group clinical supervision is a complex process. It is important that groups adhere to structure and timing so that rigorous group supervision does take place and sliding into general chat, open ended support or abstract discussion is avoided (Bond & Holland, 2010).

An action learning set is a structure which might be used or adapted in clinical supervision groups. Action learning sets consist of 4-6 members and a facilitator who meet monthly for at least 3 months to discuss the learning issues of each group member in turn (Bond & Holland, 2010).

7. Supervisor requirements

For the pilot project commencing in 2014, supervisors will be required to complete this pre-reading workbook, undertake a one day training workshop, commit to leading fortnightly group clinical supervision sessions with another co-supervisor for 2 months followed by monthly sessions for 4 months. Supervisors will also be required to attend a 4 hour workshop each month for the duration of the 6 month pilot project. Twelve supervisors will be required for the pilot project. It is expected that all supervisors will also be participants in the pilot groups.

8. Supervisee requirements

Participation in group clinical supervision will be a mandatory requirement for all APNs at the Royal Children Hospital. Thirty-six APN's will have the opportunity to participate in the pilot project. Six groups of 6 APN's will form the pilot project in 2014. Each group will be facilitated by 2 clinical supervisors who will also be APNs. Supervisees will be required to complete this pre-reading workbook and commit to participating in fortnightly group clinical supervision sessions for 2 months followed by monthly sessions for 4 months.

9. Recommended reading

Bond, M., & Holland, S. (2010). *Skills of Clinical Supervision for Nurses. A Practical Guide for Supervisees, Clinical Supervisors and Managers* (2nd ed.). Berkshire: Open University Press

Lynch, L., Hancox, K., Happell, B. & Parker, J. (2008). *Clinical Supervision for Nurses*. West Sussex: Wiley-Blackwell

10. Appendices

Appendix 1: Chapter 1: An introduction to clinical supervision. pp1-26.

Lynch, L., Hancox, K., Happell, B. & Parker, J. (2008). *Clinical Supervision for Nurses*. West Sussex: Wiley-Blackwell.