Professional/Clinical Supervision Handbook for Allied Health Professionals

2010

This publication cannot be reproduced in whole or part without the express permission of NHS Lanarkshire
Professional/Clinical Supervision Handbook for Allied Health Professionals

2010


Reviewed by: Allied Health Professions

Endorsed by: AHP Advisory Committee

Responsible Persons: Armorel Allen AHP Practice Development Lead, Pauline McCartan Professional Lead, Speech & Language Therapy, Janice McClymont Professional Lead Occupational Therapy

Previous Version/Date: Version 1, April 2010

Review Date: April 2012

Acknowledgements to: Pauline Hanlon MH Practice Development Nurse from whose work this was derived

This publication cannot be reproduced in whole or part without the express permission of NHS Lanarkshire
Why “HIGH CHALLENGE: HIGH SUPPORT”?

“Challenge sets a process in motion - it provides the motivation or energy for a response. Support helps to ensure successful adaptation.

The challenge for a newly sprouted seed is to survive and thrive until it has produced seed. It needs support in the form of light and nutrients. The challenge and the support allow it to succeed. Without the challenge (the motivation) or support (the help), the plant would wither.

In humans, support alone creates laziness. Challenge alone can be harmful. Together, challenge and support can create a myriad of adventurous growth experiences.”


Please note:

The “yinyang” symbol used throughout this handbook is not meant to represent any particular faith or belief system. The intention has been for it to represent a balance between “High Challenge” and “High Support” in the delivery of Professional/Clinical Supervision – there should be elements of support within the challenge, and elements of challenge within the support.
Contents
# Contents

<table>
<thead>
<tr>
<th>Section 1 Introduction</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 AHP Professional Guidance</td>
<td>5</td>
</tr>
<tr>
<td>1.2 Guidelines for Professional Supervision in Nursing, Midwifery and the Allied Health Professions (NHS Lanarkshire 2009)</td>
<td>7</td>
</tr>
<tr>
<td>1.3 A Statement on Professional Supervision Prepared by the Leaders of Nursing, Midwifery and the Allied Health Professions February 2009</td>
<td>7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 2 Clinical/Professional Supervision</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 What is Clinical/Professional Supervision and how will it help you?</td>
<td>9</td>
</tr>
<tr>
<td>2.2 What is it not?</td>
<td>10</td>
</tr>
<tr>
<td>2.3 Benefits of Clinical Supervision to clinical practice</td>
<td>10</td>
</tr>
<tr>
<td>2.4 An Evidence Based Model</td>
<td>11</td>
</tr>
<tr>
<td>2.5 Types of supervision</td>
<td>12</td>
</tr>
<tr>
<td>2.6 Methods of delivering clinical supervision</td>
<td>13</td>
</tr>
<tr>
<td>2.7 Principles</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 3 Responsibilities and Requirements</th>
<th>16</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Managerial responsibilities for Clinical Supervision</td>
<td>16</td>
</tr>
<tr>
<td>3.2 Responsibilities of Supervisors and Supervisees</td>
<td>16</td>
</tr>
<tr>
<td>3.3 Essential requirements of Supervisors and Supervisees</td>
<td>17</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 4 Planning, Preparation and Overcoming Problems</th>
<th>18</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Preparation</td>
<td>18</td>
</tr>
<tr>
<td>4.2 Getting started</td>
<td>18</td>
</tr>
<tr>
<td>4.3 Preparation for supervisees</td>
<td>19</td>
</tr>
<tr>
<td>4.4 The Contract/Ground Rules</td>
<td>21</td>
</tr>
<tr>
<td>4.5 Overcoming problems</td>
<td>22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 5 Governance</th>
<th>23</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Clinical Governance</td>
<td>23</td>
</tr>
<tr>
<td>5.2 Monitoring</td>
<td>24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 6 Paperwork</th>
<th>25</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Retaining records</td>
<td>25</td>
</tr>
<tr>
<td>6.2 Recording/documentation and sample paperwork</td>
<td>25</td>
</tr>
<tr>
<td>6.2.1 Contract</td>
<td>25</td>
</tr>
<tr>
<td>6.2.2 Record of supervision (for supervisees)</td>
<td>25</td>
</tr>
<tr>
<td>6.2.3 Supervision register (for supervisor)</td>
<td>25</td>
</tr>
<tr>
<td>6.2.4 Annual Evaluation</td>
<td>25</td>
</tr>
<tr>
<td>6.2.5 Annual Planning Chart</td>
<td>25</td>
</tr>
<tr>
<td>6.2.6 Reflective practice pro form</td>
<td>25</td>
</tr>
</tbody>
</table>

| Section 7 References | 32 |
Section 1

Introduction
Section 1 Introduction

“Clinical supervision is a term used to describe a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations” (Department of Health 1993).

Within Lanarkshire, Guidelines for Professional Supervision in Nursing, Midwifery and the Allied Health Professions (Section 1:2) were developed as an action of the Practice Development Board and published in February 2009. An implementation plan was drawn up, with the aim of ensuring that every Nurse, Midwife and Allied Health Professional (NMAHP) has access to adequate and appropriate professional supervision.

A scoping exercise in 2009 across the Allied Health Professions revealed that

- Clinical supervision is being practised in some areas and in parts of some professions.
- Most of the professions had professional guidelines for implementing supervision.
- Different models were recommended.
- A mixture of group and individual supervision was offered.
- Difficulties were identified regarding the allocation of time for this activity.
- Recording of clinical supervision was not standardised leading to problems in carrying out audit.
- Uncertainties and lack of preparedness were cited as obstacles to implementing supervision.
- Confusion was highlighted between line management, peer supervision, caseload review, PDP review, clinical supervision and professional supervision.

In response to a statement from NMAHP Leaders (Section 1:3) and the scoping exercise, this handbook has been developed to assist in providing a framework for implementing clinical supervision and to provide an element of consistency across the Allied Health Professions, in reporting Clinical Supervision engagement.

The purpose of this Handbook is to provide a framework for implementing clinical supervision within a practice setting, whether it be Community or Acute. It concentrates on what you need to know in respect of information and supporting documentation.

The materials are presented in a ring binder, with the different sections clearly divided. This will allow you to add your own texts, and references, and to ensure easy access to the paperwork that is recommended.
Clinical supervision is an integral part of professional practice and is recommended in professional guidance from individual professional bodies, the Health Professions’ Council (HPC), 2008 and the Nursing and Midwifery Council (NMC), 2008.

**Speech and Language Therapy**

*Communicating Quality 3 - Supervision*

“A key factor in delivering a quality speech and language therapy service is supervision. Supervision refers to a formal arrangement which enables an SLT or support practitioner to discuss their work regularly with someone who is experienced and qualified.”

Service standard 13:
The service has an up-to-date policy and system of clinical supervision for all clinical staff.

Service standard 14:
SLTs access an appropriate form of clinical supervision at least once every 12 weeks.

**Occupational Therapy**

*COT Code of Ethics & Professional Conduct, 2005 (For review 2010)*

Occupational therapy personnel shall be supported in their practice and development through regular professional supervision within an agreed structure or model.

The COT supports and encourages supervision to enable professional development and continuing education. It considers supervision to be a designated reflective exchange between two or more professionals in a safe and supportive environment which critically analyses practice to promote and enhance quality of care.

**Physiotherapy**


‘Clinical Supervision can be seen as a collaborative process between two or more practitioners of the same or different professions. The process should encourage the development of professional skills and enhanced quality of patient care through the implementation of an evidence-based approach to maintaining standards in practice. These standards are maintained through discussion around specific patient incidents or interventions using elements of reflection to inform the discussion.’
• **Audiology**

*Audiology Quality Standards (2009)*

“Competency for all clinical procedures is verified formally by peer review observation at least every 2 years for all clinical staff undertaking such procedures. Ongoing assessments of all clinical staff’s competency should also be carried out informally by local Audiology centres.”

• **Dietetics**

*BDA Practice Supervision Guidelines (2008)*

“Practice supervision is part of the Governance Framework. It should be included within working practices and not considered as an “add on”. It is integral to delivering a quality service and should be embraced by the practitioner to enhance professional practice. By exploring work-based scenarios and reflecting upon practice, the practitioner will have the opportunity to develop not only themselves, but also the employing organisation”

• **Podiatry**

*The Society of Chiropodists and Podiatrists (SCP)*

Section 1:2 **Guidelines for Professional Supervision in Nursing, Midwifery and the Allied Health Professions**  
(*NHS Lanarkshire 2009*)

These Guidelines are available on the Practice Development website under “Resources” (*access via FirstPort*).

Section 1:3 **A Statement on Professional Supervision Prepared by the Leaders of Nursing, Midwifery and the Allied Health Professions**  
*February 2009*

The NHS Lanarkshire Leaders of Nursing, Midwifery and the Allied Health Professions (NMAHPs) see it as timely and appropriate to issue this statement on professional supervision in order to:

- Support the continuation of previous and current good practice in professional supervision (also referred to as clinical supervision);
- Provide clear direction on the importance of professional supervision for every Registered Nurse, Midwife and Allied Health Professional across NHS Lanarkshire;
- Promote professional supervision as a quality, desirable and valuable experience.
- Ensure public protection is truly at the heart of NMAHP practice.

Within NHS Lanarkshire supervision (the act of ensuring correct performance) comes in many guises: for example through general management or educational mentorship to name but two. This statement focuses upon ‘professional’ supervision i.e. the process of professional support that enables practitioners to continue learning, assume responsibility for their own practice and enhance public protection and safety of care through a direct focus on professional practice. The intention of such supervision is three-fold:

- To improve professional self through lifelong learning (continuing professional development);
- To improve professional practice (continuing practice development);
- To feel and be supported as a professional (continuing personal development).

There is therefore a clear expectation that professional practitioners must engage in professional supervisory processes especially where these are already predetermined (as occurs in Midwifery, Occupational Therapy or some Psychological Interventions for example). However where professional supervision is not predetermined each practitioner, based on guidance issued by the AHP Professional Bodies, must address professional supervision using the ‘Guidelines for Professional Supervision’ (*NHS Lanarkshire 2008*).
It should be noted that for the majority of professional practitioners current KSF based Personal Development Planning and Review processes should meet professional supervisory requirements. This is provided that professional supervision (that which is conducted through and with someone from one’s own professional practice) is an intrinsic component of that relationship and interaction, and there is clear focus on practice/case review to ensure continued fitness for practice. For some professional practitioners who are managed outwith their own profession there may need to be other formal arrangements agreed to include professional supervision.

Such practitioners require to have formal professional supervisory mechanisms in place that allow for practice/case review, primarily because of potential practitioner and client vulnerability in such situations. For these professional practitioners, professional supervision must be based on the ‘Guidelines for Professional Supervision’ (NHS Lanarkshire 2008) and any additional guidance published to support specific aspects of their practice (e.g. Child Protection or Psychological Therapies Supervision).

In summary it is recommended that in whatever form professional supervision occurs, within existing and/or specific professional supervisory arrangements, it must occur for each and every practitioner. This will be a reflective process with the focus on practice or cases. Practitioner support, growth and development and quality and safety of care can be addressed and it should serve the following key aims:

- To safely appraise practice
- To develop professional skill
- To question established practice
- To seek or develop new approaches

Further advice and guidance can be obtained by contacting the Practice Development Centre.

Signed:

**Paul Wilson**  
NMAHPs Executive Director

**Peter McCrossan**  
Associate Director AHPs

**Marie Cerinus**  
Director of NMAHP  
Practice Development
Section 2

Clinical/Professional Supervision
Section 2  Clinical/Professional Supervision

Section 2:1  What is Clinical/Professional Supervision and how will it help you?

Clinical Supervision is “a process in which practice is supported and challenged through discussion and reflection with a trained supervisor, promoting safe and effective delivery of care” (Department of Health, 1993).

The NMC (2006) states that “clinical supervision is a practice-focused professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor”.

The literature around this topic is predominantly about nursing but commonality with AHP ways of working justifies adopting a similar approach.

Grant (2000) discusses the requirement for nurses to practice ethically and that through clinical supervision can explore their feelings in relation to their duty to care. Secondly, in relation to consumer need, nurses need to be able to engage in evidence based practice and be able to demonstrate professional accountability by embracing clinical supervision.

It can also support and help meet AHPs’ requirements for continuing knowledge and skills development through supporting the following processes:

- **Personal Development Plans (PDPs)**
  Clinical Supervision makes it possible for clinicians to reflect on their practice and identify individual needs/areas for improvement. It also provides the opportunity to develop expertise, to find new ways of learning, and to gain professional support, which is particularly important for AHPs if they work alone.

- **NHS Knowledge and Skills Framework (NHS KSF)**,
  Within the NHS KSF, the aim of a PDP is to focus on enabling staff to develop and apply their knowledge and skills to meet the demands of their current post as described in the NHS KSF post outline. While post outlines apply to everybody who is employed in that post, PDPs reflect what an individual needs to help them develop in their role and to link organisational and individual development needs.

- **HPC CPD requirements**
  All Allied Health Professionals are required to keep a portfolio of evidence of continuing professional development. As a supervisor as well as a supervisee, the practice of clinical/professional supervision can support this. The practice of clinical/professional supervision can support the CPD requirements of the supervisor in addition to that of the supervisee.
Section 2:2  **What it is NOT:**

- It is **NOT** psychotherapy or counselling (Yegdich 1999a)
- It is **NOT** an opportunity for managers to police staff (Yegdich 1998, 1999a)
- It is **NOT** necessarily hierarchical (as per employment structures) but may be so
- It is **NOT** performance management

Section 2:3  **Benefits of Clinical Supervision to Clinical Practice**

- Clinical supervision enables clinicians to take the emotional load of caring and have it acknowledged and worked through.
- It provides a place where personal awareness and self esteem can be increased and where areas of practice which may be hindering the clinician can be explored.
- Clinical supervision allows an exchange between practicing professionals which may promote debate, challenge existing thinking and generate solutions to problems in practice.
- It enhances and informs personal and professional development and may ultimately lead to an engagement in life-long learning.
- Clinical supervision produces a clinician/patient relationship which is committed, adequate and spontaneous.
- It encourages safe, reflective practice where the clinician is more aware and sensitive to the patients needs.


All of these highly challenging components will be delivered within a highly supportive context
Section 2:4  **An Evidence Based Model**

This document advises on an evidence based model of clinical supervision which can be used in an inpatient and in a community setting. There is a great deal of literature on the different models of clinical supervision. Sloan (2006) writes that Proctor’s (1987) model has gained increasing popularity in nursing and is probably the most frequently cited supervision model in the literature.

The Three Function Interaction Model of Supervision, Proctor (1987) and adapted in Bond & Holland (1998) provides a common framework as outlined below:

<table>
<thead>
<tr>
<th>Task</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Restorative:</strong></td>
<td>Enabling the practitioner to sustain effective work, by supportive help for those working with stress and distress. This support is achieved by the supervisor having an unconditional positive regard for the supervisee (this means holding a continual respect for the individual despite the circumstances). In this supportive setting, positive challenges to practice can be made.</td>
</tr>
<tr>
<td></td>
<td>• Establish good working alliance</td>
</tr>
<tr>
<td></td>
<td>• Listen</td>
</tr>
<tr>
<td></td>
<td>• Allow supervisee to blow-off steam</td>
</tr>
<tr>
<td></td>
<td>• Validate good practice</td>
</tr>
<tr>
<td></td>
<td>• Help supervisee to feel safe enough to be honest, reflect on personal reaction and feelings, and identify possible need for further support.</td>
</tr>
<tr>
<td><strong>Normative:</strong></td>
<td>Ensuring the practitioner maintains established standards of care by dealing with accountability aspects of practice. In the clinical supervision setting this is most powerfully achieved through reflection on practice in the supportive and challenging environment provided by the supervision relationship. It is the shared responsibility of both the supervisor and the supervisee.</td>
</tr>
<tr>
<td></td>
<td>• Provide constructive criticism</td>
</tr>
<tr>
<td></td>
<td>• Challenge practice when necessary</td>
</tr>
<tr>
<td></td>
<td>• Monitor supervisee’s adherence to their ethical code</td>
</tr>
<tr>
<td></td>
<td>• Provide supervisee with honest feedback</td>
</tr>
<tr>
<td></td>
<td>• Regularly evaluate effectiveness of supervision</td>
</tr>
<tr>
<td><strong>Formative:</strong></td>
<td>This is the educational process enabling the practitioner’s development of expertise and skills. This learning is achieved through guided reflection on practice in a safe, time protected setting.</td>
</tr>
<tr>
<td></td>
<td>• Help supervisee reflect on practice, interactions, relationships.</td>
</tr>
<tr>
<td></td>
<td>• Monitor own reactions to material brought by supervisee.</td>
</tr>
<tr>
<td></td>
<td>• Tailor session to supervisee’s level of experience and development.</td>
</tr>
</tbody>
</table>
### Section 2:5 Types of supervision

Within clinical practice, the term “supervision” can be used for a variety of different functions. To this purpose, the table below describes some commonly used forms of supervision.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseload</td>
<td>A process that involves practitioners caseloads being reviewed to include aspects of record keeping, time management, adherence to organisations guidelines and polices and to support practitioners in the development of skills and knowledge to meet health needs of their client/patient group.</td>
</tr>
<tr>
<td>Fieldwork</td>
<td>Also known as supervised practice</td>
</tr>
<tr>
<td>Managerial</td>
<td>Offered to staff who have managerial responsibilities and is generally provided by an immediate line manager (who is not necessarily from the same profession as the supervisee).</td>
</tr>
<tr>
<td>Specialist</td>
<td>For staff who are providing specialist interventions which requires focused supervision i.e. Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT)</td>
</tr>
<tr>
<td>Educational</td>
<td>For staff who are undertaking an educational training course i.e. students.</td>
</tr>
<tr>
<td>Professional</td>
<td>When a line manager is of a different discipline to the practitioner, it may be necessary to obtain specific professional supervision. This supervision may address issues about professional identity, the development of specific technical skills and training.</td>
</tr>
</tbody>
</table>
Section 2:6  **Methods of delivering Clinical Supervision**

Clinical supervision may be delivered in different ways.

**Individual:** Between supervisor and supervisee. The supervisor may be equally or more experienced/knowledgeable that the supervisee. This is the most common model of supervision, some sources suggesting that 1:1 supervision offers the greatest potential for professional growth (Gilmore, 1999). Other refs

**Group:** All supervisees within a team who work together receive group supervision from one supervisor. This may be a uni-professional or a multidisciplinary team.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>More time for supervisee</td>
<td>Full focus on individual supervisee</td>
</tr>
<tr>
<td>Opportunity to create clearer and more focused objectives</td>
<td>Input from only one person (supervisor)</td>
</tr>
<tr>
<td>Highly personalised</td>
<td>Difficulties if supervisory relationship breaks down</td>
</tr>
<tr>
<td>Supervisee can work at own pace</td>
<td>Evaluation and feedback from one persons perspective only</td>
</tr>
<tr>
<td>Non-competitive environment</td>
<td>Can become collusive with little challenge</td>
</tr>
<tr>
<td>Allows supervisee to concentrate on one particular issue</td>
<td>Can foster dependency in supervisees</td>
</tr>
<tr>
<td>Development in supervision can be easily monitored</td>
<td>Less comparison for supervisees re: other ways of working</td>
</tr>
<tr>
<td>Supervisors intentions can be geared specifically towards the learning of the supervisee</td>
<td></td>
</tr>
<tr>
<td>Strengths</td>
<td>Weaknesses</td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Input from a number of people</td>
<td>Individual’s needs may not be addressed.</td>
</tr>
<tr>
<td>Supportive atmosphere from peers</td>
<td>Individuals may get “lost” or “hide” within the group</td>
</tr>
<tr>
<td>Values of listening to others describe their work and problems they face</td>
<td>Maybe a lack of time for group members with large case loads</td>
</tr>
<tr>
<td>Cost effective in time and economics.</td>
<td>Not all are suited to group work</td>
</tr>
<tr>
<td>Can allow experimentation with other interventions</td>
<td>Can be used as a “dumping ground”</td>
</tr>
<tr>
<td>Can help supervisees deal with issues of dependency on supervisors.</td>
<td>Group dynamics may temporarily impede the task</td>
</tr>
<tr>
<td>Evaluation and feedback from a number of people.</td>
<td>Pressure to conform, “Group think”</td>
</tr>
<tr>
<td>Risk taking can be higher in a group setting</td>
<td>Difficulty for newcomers to enter group</td>
</tr>
<tr>
<td>Emotional support from peers</td>
<td>Some topics may not be of interest to other group members</td>
</tr>
<tr>
<td>Issues arising from within the group can be addressed</td>
<td>Lessening of confidentiality</td>
</tr>
<tr>
<td>Dilutes power of supervisor</td>
<td>Overload for some members</td>
</tr>
</tbody>
</table>

*Hawkins and Shohet, 1992, Supervision in the Helping Professions, OU Press*
Section 2:7 **Principles**

Within NHS Lanarkshire Clinical Supervision: Code of Practice (2002) it states there are many underpinning principles and values for clinical supervision including, personal and professional lifelong learning, support, commitment, accountability and responsibility.

The following principles will underpin clinical supervision:

- All professional and clinical support staff will receive clinical supervision
- Supervision will be offered on a formal basis
- And delivered individually or on a group basis.
- The supervision model will reflect an evidence based model.
- Supervision will reflect values based practice.
- Protected time will be allocated to the session.
- Supervisees should be able to choose their own supervisor
- Each supervisory relationship will have a formulated contract to follow with record sheet and reasons for non-attendance.
- Supervision will occur at regular intervals and for up to 45 minutes (or at a frequency and time agreed within supervision contract).
  - Records of attendance at sessions will be kept by the supervisor, to enable audit to be carried out.
  - Records will be kept, by the supervisee, to provide evidence of CPD and personal development
  - An annual report will be required from supervisees, outlining changes in practice and professional development.
- The venue will be a quiet area, free from distractions and interruptions

All Allied Health Professionals who currently practice clinical supervision will be required to carry out a self-audit to match their practice of clinical supervision against the principles stated above
Section 3

Responsibilities & Requirements
Section 3  Responsibilities and Requirements

Section 3:1  Managerial Responsibilities for Clinical Supervision

To allow for the implementation of clinical supervision, managers will commit to offering protected time to clinicians to engage meaningfully in their supervision sessions.

45 minutes is recommended as the time each session should last, however agreement between the supervisee and supervisor as to what is required to cover the supervision agenda can be recorded in the contract. Whilst acknowledging the potential resource implications that this may impose on the organisation, it is a small price to pay given the investment will facilitate and develop practitioners who will be in a position to provide safe, modern, evidenced based quality care of patients/clients.

Section 3:2  Responsibilities of supervisors and supervisees

It should be noted from the outset that the supervisor and supervisee should understand and maintain within their supervision the following responsibilities:

**Supervisor**
- Establish a safe environment
- Explore and clarify thinking
- Give clear feedback
- Share information, experience and skills
- Confront personal and professional blocks
- Be aware of organisational contracts
- Respect confidentiality, unless disclosures conflict the law or professional code of conduct
- Keep a record that supervision has taken place
- The supervisor will keep such notes as deemed appropriate and share them with the supervisee
Supervisee

- Initiation and organisation of their own personal, professional and practice development and relevant supervision arrangements
- Awareness of their professional codes of conduct and competencies, where relevant.
- Identification of practice issues for exploring and improvement of practice
- Preparation of any materials that might be needed for the session
- Exploration of interventions which are useful
- Be open to feedback and develop an ability to use this constructively
- Accountable for his/her work and informing their manager and clinical supervisor of any difficulties
- Ensure that they fulfil their supervision contract with their clinical supervisor
- Keep their manager informed of their clinical supervision arrangements
- Keep notes on the outcome of each session and record when it has taken place.

Section 3.3 Essential Requirements

The Essential Requirements for a Skilled Supervisor are:
- Managing
- Listening
- Supporting
- Summarising
- Challenging
- Feedback

The Essential Requirements for a Skilled Supervisee are:
- Reflecting
- Experimenting
- Conceptualising
- Planning
- Experiencing emotion (Milne & James 2002)
Section 4

Planning, Preparation & Overcoming Problems
Section 4 **Planning, Preparation and Overcoming Problems**

Section 4:1 **Preparation**

Preparation of those undertaking supervision, whether as a supervisor or as a supervisee, will be given through provision of learning materials, followed by optional attendance at short group sessions, in which skills in active listening, challenging with support and facilitation of reflective practice will be developed. This handbook will serve as an aide-memoire and as a resource for ongoing use. Where identified in personal development plans, additional training and learning opportunities will be developed. NHSL is committed to supporting preparation to deliver supervision.

Section 4:2 **Getting Started**

- **What method of delivering supervision will be used?**
  Clinicians may receive supervision either individually or in a group. Some sources suggest that 1:1 supervision offers the greatest potential for professional growth (Gilmore, 1999), however, group supervision can also be effective to members of a team who share similar working practices.

- **Limits and boundaries**
  Participants should agree to abide by the HPC Professional Code of Conduct and codes of conduct of their individual professions. In the case of a possible breach of these codes, agreement is reached as to how to proceed. Discussions are in confidence, other than the supervisor’s own supervision (however, supervisee will remain anonymous).

  The supervisee keeps their own notes and the supervisor can keep brief notes (optional) that are agreed with supervisee.

  Boundaries are set in terms of supervision being accepted as an exploration of the supervisee’s work and their thoughts and feelings about the work. It is understood that personal counselling, managerial and casework is not part of the supervision process.
Protected time

It is essential for clinicians to be given the time to engage meaningfully in their supervision sessions. This time allocation should be a minimum of 30 - 45 minutes per month (or as required to cover supervision agenda) and free from distraction. Time used for supervision is part of CPD allocation as accounted for in capacity planning.

The challenge for high risk clinical areas where activity levels can be unpredictable is down to careful organisation of the process so that staff do not lose out. The same can be said for community teams where common obstacles such as telephone interruptions and clinical emergencies have to be managed effectively in order to allow the process to continue.

Frequency, Duration and Venue

The required frequency and duration of supervision sessions should be negotiated on an individual basis between the supervisee and supervisor. This should then be agreed with the supervisee’s manager and specified in the supervision agreement.

The requirement of a quiet area free from interruption is essential. Carter (2005) states that the perceived quality of supervision is higher for those nurses who hold sessions away from the workplace.

Section 4:3 Preparation for Supervisee

Clinical Supervision sessions need to be prepared for and carefully structured and managed with clearly defined aims and objectives. Identifying topics for discussion and estimated time to be spent discussing them is important, so as to progress through the supervisee’s agenda within the given time.

Sometimes it is hard to think what to discuss in a session. You can start by considering these themes:

- Something that went well for me .................................................................
- What drove me nuts about today was ..........................................................
- What I tried to do in this situation was ........................................................
- Something that bothers me about what I do is ...........................................
- If I had the chance to do that again I would ................................................
- I really think that I need to know more about .............................................
Ooijen (2003) describes a 3-Step Method to structure a session:

**Step 1: WHAT?**
- What do I need to know?
- What do I want to talk about?
- What is my objective in doing that?
- What do I want to achieve?
- What is the real issue here?

**Step 2: HOW?**
- How am I going to take this forward?
- How am I going to find out?
- What do I feel is helpful here?

**Step 3: WHAT NOW?**
- What do I think and feel Now?
- What might I need to think about Now?
- What steps do I need to take now?
- What will I do Now that I have found out what I wanted to know?

Other topics which may be used within a Clinical Supervision Session:

1. Supervisory role which a supervisee may undertake where appropriate.
2. Individual/personal development (offering practical/emotional support where required).
3. Training possibilities identified
4. Interpersonal and team issues
5. Policy and practice issues
6. Information giving and clarification
Section 4.4  **The Contract/Ground Rules**

In setting up clinical supervision, it is essential that the boundaries of the supervisory relationship are established through the explicit drawing up of the ground rules via a mutually negotiated supervision contract (Rolfe et al, 2001).

Basic ground rules should be discussed, agreed and be clearly visible in the contract, which both the supervisor and supervisee should sign at the initial session.

The following factors need to be considered in drawing up a contract:

- Linking and communicating with managers
- Commitment from both parties to make themselves available for agreed sessions
- The need for punctuality
- Commitment from the supervisee to prepare an agenda for each session
- Agreement on the understanding of confidentiality and recording of the sessions
- Agreements to ensure that the supervisee understands that the sessions will be both **challenging** and **supportive**
- Arrangements for reviewing the contract should be made yearly as specified in contract or at the request of either party
- Supervisor and supervisee must agree to show respect and loyalty to the supervision session
- In the event of either being dissatisfied with the process, it should be agreed that issues are, in the first instance addressed within the supervision relationship
- Supervisors are responsible for keeping their records of supervision, these need to be available for audit purposes i.e. confirming that a session has been held
- In accordance with guidelines for record keeping, all records on clinical supervision should be kept for six years (NHSL 2004)
- The frequency, duration and venue for the sessions.
Section 4.5  **Overcoming Problems**

- **Changing Supervisor**
  Most of the literature recommends that staff choose their own supervisor. Current practice reflects that a hierarchical model is most often chosen as the method of delivery of supervision. This method is not to be criticised, however the choice of supervisor should, where possible be made open and flexible to all staff. The responsibility of current supervisors will be to identify and support which option staff choose to take. The advice would be to select a supervisor who has the capability, knowledge and experience to provide challenge and support in developing one's own practice. This will not necessarily be someone in a higher payband.

  Lack of challenge leads to ineffective supervision. For specific issues, it might be necessary to find a different supervisor for short periods.

- **Changing Model**
  Where the Handbook has been prescriptive in the model that it is recommending, it recognises current good practice, allowing current models to be followed if they meet with the principles stated. All current models will be audited against the principles and in the cases where they don't meet the requirements, will change to fit with the stated requirements.

- **Suspicion, Resistance, Tokenism and Mutiny**
  These are common problems when introducing new practice, however, it is hoped that the approach being used will offer clarity, openness and collaboration with the supervisory relationship, so maintaining the integrity of professional practice.
Section 5

Governance
Section 5  **Governance**

Section 5:1  **Clinical Governance**

Clinical supervision and clinical governance are not interchangeable. They are two separate, but essential concepts that encompass the principles of continuous quality improvement. Within clinical governance, clinical supervision is a key ingredient in improving quality through staff support and development.

Clinical supervision is vital to the framework of clinical governance because it ensures:

- Continuing professional development
- Opportunities for continuous improvement and lifelong learning
- Plays a fundamental role in fulfilling an individuals and organisations responsibility under corporate governance
- Helps to ensure better and improving clinical practice and client care
- Improved service delivery through the use of evaluation systems.

Clinical supervision provides a structured approach to deeper reflection on clinical practice and is important as a tool to support the following elements of clinical governance:

- Quality management
- Risk management
- Systems of accountability and responsibility.
Section 5.2 Monitoring

The monitoring and governance of clinical supervision will be encompassed through

- NHSL Senior Charge Nurse/Team Leader Performance Objectives 2010/11

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Outcome</th>
<th>Timescales</th>
<th>KSF</th>
<th>Education &amp; development framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Team is motivated and their performance and effectiveness is monitored.</td>
<td>Shared goals and vision for care provision are articulated which relate to the purpose, function and practice of the team. Leadership skills are used to communicate, motivate and mobilise the team towards shared goals. Professional supervision, Support and/or Mentorship is available to all staff.</td>
<td>Monthly and ongoing</td>
<td>Core 2 level 4 indicator d, g, h G6 level 2 indicator c, d</td>
<td>Dimension 1.1 Dimension 3.1</td>
</tr>
</tbody>
</table>

- **Annual Reporting** by supervisees and supervisors, on outcomes achieved, will also contribute to the monitoring process.
Section 6

Paperwork
Section 6  **Paperwork**

Section 6.1  **Retaining Records**

In accordance with guidelines for record keeping, all records on clinical supervision should be kept for six years (NHSL 2004).

Section 6.2  **Recording Documentation**

Examples of documentation have been provided in this pack to help structure and record the sessions. The following samples are provided:

- Contract for Clinical Supervision
- Record of Clinical Supervision
- Supervision Register
- Yearly Planner
- Annual evaluation for supervisees

These examples can be copied and used, although if required by professional codes, specific uni-professional paperwork can be adopted. Each profession is responsible for ensuring that the information required from NHSL in order to carry out audit and monitoring is included in the documentation used.

Some professional bodies provide recommended documentation and the examples given should not replace these. However, it is recommended that uni-professional documentation is benchmarked against these examples.
Sample Contract for Clinical Supervision

Prior to agreeing this contract the supervisor and supervisee should discuss:

- The expectations of supervision and any anxieties surrounding the sessions
- The importance of regular feedback between supervisor and supervisee to enable effective supervision to occur

Clinical Supervision Contract

<table>
<thead>
<tr>
<th>Aims of supervision</th>
<th>Honest reflection on practice to maintain and improve standard of work, facilitated with support and challenge.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Frequency of sessions</th>
<th>Duration of session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Venue</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Review/Evaluation</th>
<th>date set or after</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(One year on)</td>
</tr>
<tr>
<td></td>
<td>(number to be agreed) sessions</td>
</tr>
</tbody>
</table>

Ground Rules

Confidentiality

Although the supervisor will not normally take what is discussed outside the sessions, where illegal, unprofessional or unethical practice is disclosed, this may be necessary. The supervisee would in the first instance be encouraged to self-report.

Code

We agree to abide by the HPC and (own profession) Code of Professional Conduct

Respect

We agree to show respect and loyalty to one another

Punctuality

We agree to be punctual

Accountability

The supervisee is accountable for his/her own practice and decides what to bring to supervision.

Responsibilities

Agenda will be set by the Supervisee unless otherwise agreed

Note-taking

The supervisee will keep notes which can be shared with supervisor. The supervisor will keep a record of the sessions.

Cancellations

We agree to give notice of our non-attendance in advance, quickly rearranging the session

We agree to be bound by the contract and ground rules above: Date

Supervisor name signed

Supervisee name signed

In accordance with guidelines for record keeping, all records on clinical supervision should be kept for six years (NHSL 2004).
**Sample Record of Clinical Supervision** (to be retained by Supervisee)

<table>
<thead>
<tr>
<th>Supervisor</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisee/s</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>Start time</th>
<th>Finish time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic/subject brought to supervision</th>
<th>Issues Arising:</th>
<th>Action:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date of Next Meeting:

---

This publication cannot be reproduced in whole or part without the express permission of NHS Lanarkshire
### Sample Supervision Register

(To be used to monitor activity for individual, group supervision and retained by Supervisor)

<table>
<thead>
<tr>
<th>Name of supervisor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of session</td>
<td></td>
</tr>
<tr>
<td>Time of session</td>
<td></td>
</tr>
<tr>
<td>Venue</td>
<td></td>
</tr>
<tr>
<td>Supervisee/s in attendance</td>
<td></td>
</tr>
<tr>
<td>Supervisee/s apologies</td>
<td></td>
</tr>
<tr>
<td>Reason for non-attendance</td>
<td></td>
</tr>
</tbody>
</table>

**Monitoring**

Please keep a copy of this register in your Clinical Supervision Folder for audit purposes
Sample Annual Evaluation of Clinical Supervision

(to be completed by both supervisor and supervisee and sent to Team leader for monitoring purposes)

<table>
<thead>
<tr>
<th>Date Evaluation Completed</th>
<th>Supervisor report or supervisee report (circle as appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisee Name</td>
<td>Name</td>
</tr>
<tr>
<td>Supervisor Name</td>
<td></td>
</tr>
<tr>
<td>Group or 1:1 supervision?</td>
<td>Please specify</td>
</tr>
<tr>
<td>Number of sessions attended</td>
<td></td>
</tr>
<tr>
<td>Number of sessions missed</td>
<td></td>
</tr>
<tr>
<td>Reasons for missed sessions</td>
<td>Please give reasons for each date</td>
</tr>
<tr>
<td>What have you gained from your clinical supervision sessions?</td>
<td>Please give details</td>
</tr>
<tr>
<td>Has clinical supervision resulted in any change in practice for you?</td>
<td>Please give details</td>
</tr>
<tr>
<td>How could the sessions have been more useful?</td>
<td>Please give details or suggestions</td>
</tr>
<tr>
<td>Do you have any views on the way the sessions were conducted?</td>
<td></td>
</tr>
<tr>
<td>Any other comments?</td>
<td></td>
</tr>
</tbody>
</table>
## Sample Annual Planning Chart

<table>
<thead>
<tr>
<th>Method</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDPR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CL Sup</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Sup</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: this is an example of a planner which might be used by an individual (to record and plan their own activity) or by a manager (to keep track of when and with whom supervision is occurring).

There is no requirement to use this format.
Sample Reflective Practice pro-forma

(for the use of the supervisee as evidence in CPD reflective portfolio)

Reflective Practice

Name of Course/Activity/Situation

Date ...............................................................  no of hours ...........................................................

Location ........................................................................................................................................

Description of learning activity ....................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................

Expected gain ....................................................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................

What have I learned? ..............................................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................

Influence on practice and patient care:

...............................................................................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................

What ideas has this given me for follow up study/development?

Has it identified any further training needs which may be required? ...............................................

...............................................................................................................................................................

...............................................................................................................................................................

...............................................................................................................................................................
Section 7

References
Section 7  References


Clinical Supervision Audit Report (2007). Mental Health Services. NHS Lanarkshire


Hughes L & Pengelly P (1997) **Staff Supervision in a Turbulent Environment**. Atheneum Press Gateshead, Tyne and Wear


NHS Knowledge Skills and Framework
http://www.dh.gov.uk/en/Policyandguidance/Humanresourcesandtraining/Modernisingpay/Agendaforchange/index.htm


Nursing & Midwifery Council (2006) **Advice Sheet on Clinical Supervision**. NMC, London


Wilken, P. (1998). **Clinical Supervision and Community Psychiatric Nursing**. Cited in

