**Foreword**

This program has been designed to develop your skills and expertise, and increase your confidence in clinical supervision.

Whether you are a nurse, doctor, social worker, physiotherapist, occupational therapist, pharmacist or other allied health professional, your contribution to clinical supervision is crucial in providing valuable learning experiences for students, interns and graduates.

Increasing the competence and the expertise of our clinical supervisors using an interprofessional approach leads to increased communication and collaboration in our teamwork. This in turn leads to better clinical outcomes and shorter hospital stays for the patients accessing our health service.

The term ‘clinical supervision’ can be confusing because it means different things to different people. In order to understand the complexities, and multifaceted nature of clinical supervision, and reach a universal understanding of what it might mean, St Vincent’s Hospital Sydney has developed an interprofessional program known as the ‘Supervision, Training and Readiness Program’ – (The STAR Program).

If you are new to the supervisor role, we believe this program will give you the knowledge to underpin your supervision abilities. If you are already a supervisor, we hope the program will give you some new insight to further enhance your skills.

We hope you enjoy this exciting, innovative approach to developing your skills and expertise as a clinical supervisor and that this handbook is a useful resource to accompany the program.

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Director Allied Health
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Interprofessional Education

The Garling report identified teamwork and communication across the disciplines as two areas that must be actively fostered in our clinicians.

Interprofessional learning has gained momentum internationally and has been shown to improve collaboration and quality of care. Interprofessional Education (IPE) involves two or more professions learning with, from and about each other. When we talk about interprofessional learning and clinical supervision we are not talking about assessing discipline specific skills, or doing each other’s roles it’s about developing an understanding and appreciation for each other, and supporting each other in doing the best for the patient.

When the professions learn from each other and about each other they work in unison, they develop positive, cohesive working relationships which lead to improved job satisfaction and retention of more highly trained staff in the healthcare setting.

Interprofessional teaching and supervision can prepare health professionals for team-based care or interprofessional collaborative practice (IPCP).

A growing amount of evidence has emerged outlining the benefits of IPCP which include:

- increased staff motivation, well-being and retention
- decrease in staff turnover
- increased patient satisfaction
- increased patient safety
- increase in appropriate use of specialist clinical resources
- reductions in patient mortality and critical incidents, and
- an increase in access to and coordination of health services.

IPE activities can:

- Enhance the learners understanding of other professionals roles and responsibilities
- Foster mutual respect
- Promote teamwork and collaboration

Some challenges of using IPE to facilitate learning include:

- Difficulty getting people together from different geographical areas due to time/schedule clashes
- Overcoming the silo/tribe mindset
- Obtaining buy-in from management/supportive workplaces

(WHO 2010)
Clinical supervision is...

“Supervision is a formal relationship in which the supervisor’s task includes imparting expert knowledge, making judgements of the trainee’s performance, and acting as a gatekeeper to the profession”

“Clinical supervision is an intensive, interpersonally focused relationship in which the supervisor is designated to facilitate the development of therapeutic competence in the supervisee”

“Clinical supervision is considered a vital part of modern, effective healthcare systems”

“Effective supervisors observe, mentor, coach, evaluate, inspire and create an atmosphere that promotes motivation, learning and professional development”

“A social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality clinical care”

“Supervision is an intervention that is provided by a senior member of a profession to a more junior member or members of that profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s) and monitoring the quality of the professional services offered”

“Clinical Supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with 4 overlapping foci: administrative, evaluative, clinical and supportive”

“Clinical supervision is imperative to both quality improvement and successful implementation of evidence based practices”

“Clinical supervision ensures delivery of high patient quality care and treatment through accountable decision making and clinical practice”

Bernard & Goodyear, 1992
Holloway, 1997
Milne, 2007
Powell, 2004
HETI Superguide, 2012
Health Workforce Australia’s *Clinical Supervision Support Framework* (HWA 2011, p.4) defines ‘clinical supervision’ as:

> ‘the oversight – either direct or indirect – by a clinical supervisor of professional procedures and/or processes performed by a student or a group of students within a clinical placement for the purpose of guiding, providing feedback on, and assessing personal, professional and educational development in the context of each student’s experience of providing safe, appropriate and high-quality patient care.’

Although clinical supervision is a core component of contemporary professional practice, it has a long and established history in many health care professions. The routines, beliefs and practices of clinical supervision began emerging as soon as healthcare workers began to train others (Leddick & Bernard 1980).

The definition of clinical supervision, as well as the preferred models and frameworks for implementation vary within and between professional groups and practice settings (Milne 2007), and still mean different things to the different disciplines that began developing their own ways and manners of supervising (Watkins 1997).

There are a variety of models and approaches to clinical supervision, and in NSW Health there is a diversity of organisational structures and clinical teams that will impact on the manner in which supervision is provided. It is important to acknowledge that there is no one model or method that would adequately cover this diversity, or the needs of all supervisors and supervisees.

The STAR Program does not represent one particular model, it adopts the notion that good supervision extracts and adapts activities and techniques in accordance with the relationship, the reaction and the outcome of the situation. It is important to be creative and to consider how to use available resources to suit individual supervisory needs.

The STAR Program is designed to help you understand the multifaceted nature of clinical supervision, and will assist you to practice and enhance your skills in components that contribute to effective clinical supervision. These components include:

- Providing constructive feedback & effective debriefs
- Facilitating reflective practice
- Peer/group mentorship
- Adult learning principles and styles
- The fundamentals aspects of clinical supervision
Studies show that effective clinical supervision leads to improved well-being, confidence and self-awareness, reduces emotional strain and burnout, and individuals experience greater professional growth. For the workforce it increases staff morale, job satisfaction, staff proficiency and retention of a more highly skilled workforce (White & Winstanley 2010).

Studies also show that the positive impact that clinical supervision has is most likely a result of the training that supervisors receive, the quality of supervision they provide and the culture and managerial attitudes in the organisation (White & Winstanley 2010).

Often there is an assumption that good clinical practice equates to good supervision skills (Haynes, Corey & Moulton 2003) and the core skills required of a supervisor are not clearly articulated, and supervisors are selected based on seniority or availability rather than suitability (Bonello 2001; HWA 2010). While observing experienced clinicians at work is without a doubt a useful training tool, it is not sufficient to help students, new graduates, interns or junior staff develop the skills and knowledge necessary to become skilled clinicians themselves. A clear description of the supervisor role supported by education and training contribute to increasing supervisor competence (Milne & James 2002; Kirke et al 2007; HWA 2010).

Often there is common agreement about what constitutes poor supervision, but less clarity about what is good supervision (Magnuson et al 2000) and while good supervision reduces errors and improves the quality of patient care, inadequate supervision is a contributing factor in critical incidents with poor patient outcomes (Kirk et al 2000).

Good supervisors are as unlikely to have a desired effect in unhealthy cultures as poor supervisors are in a healthy culture (White & Winstanley 2010). Introducing clinical supervision to a workplace does have resource, cost and time implications, but the benefits far outweigh the potential consequences of an unskilled and unsupported workforce.

In order for clinical supervision to be part of organisational culture and to achieve the best possible outcomes there needs to be adequate facilities, motivated staff and support from management. To achieve these recommendations we must ensure that:

- Clinical supervision universally considered as part of core business.
- Clinical supervisors do not hold operational or managerial responsibility for the supervisee.
- Clinical supervision is written into all workforce documents and organisational policies and procedures.
Clinical supervisors are educationally prepared for their role to an efficacious standard.

Administrative records surrounding clinical supervision are maintained and kept as per the NSW Government State Record Requirements www.records.nsw.gov.au.

Ongoing support and training for clinical supervisors is available. (White & Winstanley 2010).

The Characteristics of a Supervisor...

The relationship that develops between supervisor and supervisee is complex and its quality depends on several factors, including: the attributes of the supervisor and the supervisee, the values of the supervisor and the student, the student’s motivation and skills, communication, culture and environment.

Every supervisor has qualities that are uniquely their own, but a clinical supervisor should reflect on their own personal attributes and characteristics and how they impact on the supervisory relationship.

Studies (Baird 2003, Haynes et al 2003) reveal that the main characteristics that students are looking for in their supervisors include:

- Expertise
- Flexibility
- Understanding
- Availability
- Ability to provide meaningful feedback
- Openness to discussion
- Ability to offer support
- Empathy
- An ethical practice
Studies (Haynes et al 2003) also explored the characteristics that students consider to have a negative impact on their clinical supervision which included:

- Lack of interest
- Lack of availability
- Rigid approach
- Lack of knowledge and experience
- Lack of reliability
- Irregular feedback
- Overly critical approach
- Lack of empathy
- Lack of organisational structure
- Lack of professional ethics

To have a good experience, supervisees want to...

- Have a supportive learning environment
- Be supported
- Be given responsibility for patient care
- Receive feedback
- Be stimulated to learn
- Have a supervisor take a personal interest

(White & Winstanley 2010)
Activity – List the positive characteristics that you possess that make you a good supervisor...

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**Supervisor – Supervisee Relationships**

The importance of positive relationships, together with one that supports learning and promotes best practice has been demonstrated in more than 50 years of psychology research which highlights that:


- The need to belong induces conformity behaviours and engagement in behaviour that they know is not best practice.

- Supervisory and learning opportunities to practice in the clinical setting are increased.

- A culture of support offers students the psychological safety necessary to
  - ask and respond to questions,
  - make and learn from mistakes,
  - and initiate additional learning opportunities.

- Mutual respect and positive regard is fostered which reduces student anxiety and enhances cognitive function.

- There is an increase in the capacity for trust, and for open and honest feedback that encourages self-awareness and reflective learning.

(Cited in Siggins Miller Report 2012)

Poor supervisory relationships have an adverse impact on learning and wellbeing and have been reported to include:

- Failure to listen
- Condescending and insensitive mannerisms
- Unreasonable work demands and criticism
- Negative and humiliating comments
- Ineffective communication
- Abuse of the supervisor’s power
- Violation of ethical codes prescribed by professional bodies

(Cited in Siggins Miller Report 2012)
Building a positive relationship with your supervisee includes:

**Being Available** – schedule private meeting times with your supervisee, touch base with them regularly and stop to listen when they approach you outside of supervision.

**Being Aware** – supervisors need to be aware of the supervisee’s level of competence, scope of practice, what their learning style is and what the supervisee’s learning objectives are.

**Being Organised** – make the most of the little time there is for clinical supervision activities by being organised and prepared.

**Being Empathetic** – remember that we all started as learners and that everyone has a first time that can make them nervous and anxious. Use this insight to support and understand your learner.

**Showing Respect** – regardless of any individual differences (such as age, gender, race, religion, sexual orientation or other) and regardless of the level of experience respect should form the basis of the supervisory relationship.

**Developing Trust** – show confidence and a degree of trust in your supervisee, allow them some autonomy to seek learning opportunities and activities that interest them.

**Setting Expectations** – setting clear expectations and objectives prevent uncertainty, frustration and resentment which can all cause breakdown of a positive relationship.

**Maintaining Confidentiality** – supervisees will feel more comfortable confiding in you about matters of a more sensitive nature, and be honest about errors or lack of capability if they know it is in confidence. However, disclosure of confidential matters should be escalated to management when there are serious concerns or breaches of policy and protocol.

**Being Friendly and Approachable** – supervisees that feel comfortable and happy in the company of their supervisor are more likely to communicate with and learn from their supervisor.

**Setting Boundaries** – ensuring clear boundaries help to minimize stress and conflict in the supervisory relationship and it is important to let the supervisee know what is and isn’t acceptable behavior, practice, conduct, topic for discussion (i.e. personal matters).

**Providing Explanations** – setting rules or giving instruction without explanation can be confusing and discouraging for your supervisee if they do not fully understand the rationale or implications.

**Being Supportive and Positive** – encouragement and enthusiasm from the supervisor promotes an honest collaborative supervisory relationship.

(HETI -Superguide 2012)
While there is a lot of emphasis on the supervisor’s contribution to the relationship and the learning environment, the supervisee also has a significant role and should be expected to take responsibility for the quality of their learning experience as well.

Make your expectations of the supervisee clear, the supervisee’s should:

- Actively participate in the supervision process.
- Express their needs and expectations.
- Be prepared and organised for supervision activities.
- Make an effort to protect their scheduled supervision times.
- Be prepared to openly discuss challenging practice issues.
- Be prepared to constructively accept feedback that might be difficult to hear.
- Respond to feedback and debriefing in a progressive manner.
- Maintain the trust and respect of the supervisor.
- Contribute to reflective discussions about practice experiences and learning’s.
- Be prepared to be challenged in a supportive way.
- Be open to learning and improving clinical practice skills.
- Raise any concerns that you have and seek help when required.
- Maintain patient safety and well-being at all times.
- Not perform activities that they are unfamiliar with, or are out of the scope of practice.
- Be self-directed and committed to their ongoing professional development.
- Communicate any changing learning needs or issues that may affect the learning experience.

(Activity – Can you think of any additional expectations that you might have for your supervisee’s?)

(HETI -Superguide 2012)
**Common Challenges for the Supervisor**

There are often many challenges for supervisee; anxiety, fear, overload, lack of confidence, lack of knowledge and understanding, an unsupportive or time poor supervisor to name a few.

But what about the supervisor, what challenges do they have?
- lack of time,
- lack of departmental/colleague support,
- lack of formal training
- personality mismatches

**Behaviours & Personalities**

People’s behaviours and personalities can be the most frustrating part of any relationship, especially a professional relationship where professional boundaries must be maintained. Personality mismatches often occur and if neither supervisor nor supervisee can be tolerant and accepting of the different traits then it may be more beneficial for them to have an alternate supervisor.

However, behaviours manifest in many different ways and it is important to remember that there is generally a reason for the behaviour, and finding that reason can help to resolve the behaviour.

Resistant behaviours in the supervisee can be verbal or non-verbal and are often displayed as hostile, despondent and at times argumentative demeanours. It is a form of self-protection; a coping mechanism intended to reduce anxiety in an individual when they feel there is a perceived threat (Liddle 1986). These perceived threats usually relate to fear; fear of
failing, fear of inadequacy, fear of negative feedback and criticism, fear of making a mistake and sometimes related to personal matters.

On the other hand, if the supervisee lacks self-confidence they may be seeking approval, or reassurance. They may have a strong need to be liked and appreciated. Occasionally, supervisee’s that display resistant behaviour will do so, consciously or unconsciously, in the form of ‘game playing’ in an attempt to exert control and manipulate the supervisor. Common variations are:

- **Flattery** – intended to inhibit the supervisors focus by putting them in a good mood making them more amenable and more likely to ignore any shortcomings.

- **Ambiguity** – attempts to create vagueness and uncertainty in the relationship can lead to inability to perform accurate assessments and create a culture of blame.

- **Self-depreciation** – if the supervisor pities the supervisee, they are less likely to focus on and critique poor performance, or are more likely to reward them for inadequate performance.

- **Power disparity** – attempting to demonstrate that they are smarter and more knowledgeable than the supervisor.

- **Deflection** – directing questions or discussions away from their performance, sometimes to target someone else.

- **Seeking others** – approaching others for help and support not only undermines and erodes the supervisor’s authority, but can also lead to others questioning the supervisor’s commitment and ability.

- **Blaming** – convincing themselves and the supervisor that other people (sometime including the supervisor), or external factors are to blame for their ineffectiveness and lack of learning.

It is important to recognise that ‘game playing’ becomes a recurrent pattern, and if your supervisee only occasionally behaves in any of the above ways, it doesn’t necessarily mean they are ‘game playing’.

However if there is a reliable pattern, counteracting the behaviour and refusing to ‘play’ are the easiest ways to cope and resolve the behaviour.

It is very dependent on the individual’s personalities, the dynamics of their relationship and the behaviour being displayed as to which strategies would be most useful. But, some useful strategies include:

- **Discussing the conflicts and sharing awareness of the game playing**
- Identifying the source of anxiety or threat by way of a debrief
- Describing and interpreting the resistant behaviour
- Constructively feedback on the behaviour
- Clarifying aspects of the behaviour and seeking understanding
- Having a general discussion of resistant behaviours in an attempt to get the supervisee to recognise their errors.
- Ignoring the behaviour; when the supervisee realises it doesn’t work, they may stop, or change tack.
- Continuing to build a positive rapport with the supervisee.

(Ricketts & Donohoe 2000)

Though it may appear to be, not all behaviour is resistant. Don’t jump to conclusions and determine what the problem is without attempting to talk to the supervisee first. Often there are performance issues that can stem from an array of underlying causes. Below are just some of the potential issues and causes:

<table>
<thead>
<tr>
<th>Work Performance Issues</th>
<th>Underlying Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lateness, absenteeism or work avoidance</td>
<td>Relationship, accommodation, transport, financial, childcare issues</td>
</tr>
<tr>
<td>Poor clinical skills, knowledge and judgement</td>
<td>Ill physical or mental health, unhealthy lifestyle, addiction or substance abuse</td>
</tr>
<tr>
<td>Poor language and communication skills</td>
<td>Excessive workload, unfamiliar clinical environment, lack of personal/familial support</td>
</tr>
<tr>
<td>Unable to follow direction, policy/procedure or seek advice</td>
<td>Bullying and harassment</td>
</tr>
<tr>
<td>Lack of insight into their limitations and over performing</td>
<td>Clinical situations being comparable to or reminiscent of personal situations which can be upsetting</td>
</tr>
</tbody>
</table>
Excessive tiredness, self-neglect, withdrawal from activities, staff and patients

Unsettled by frequent transitions to new environments

Unethical behaviour or inappropriate interactions

Being ill-equipped or unadvised

Sometimes relationships cannot be built, behaviours cannot be rectified and minor performance issues cannot be resolved. In these instances, it is important to escalate matters for appropriate management and conduct. As a supervisor you should not be expected to performance manage individuals that you are supervising.

(The Superguide2010)

**The Principles of Adult Learning**

Understanding your learner’s personality and preferences, understanding the principles of adult learning and the different learning styles can help you understand how to create an effective learning environment for your supervisee.

Malcolm Knowles was the first to theorise how adults learn and described adult learning as a process of self-directed enquiry. ‘Creating change is the motivator for most adults to engage in any learning experience; changes in their skills, their behaviour, their knowledge level and even their attitudes’. Knowles suggested fostering a cooperative learning environment based on mutual trust and clarification of mutual expectations (Knowles 1970) using the following principles of adult education:

- **Adult learners need to be respected, valued and acknowledged for their past experience and have an opportunity to apply this experience to their current learning.** They need to be able to connect previous experiences to new learning experiences in order to acquire new knowledge.

- **Adults learn best in environments that reduce possible threats to self-concept and self-esteem and provide support for change and development.** They become ready to learn when they experience a life situation where they need to know.

- **Adult Learners are highly motivated to learn and in areas relevant to their current needs, often generated by real life tasks and problems.** They need to know why they should learn something and need to see that acquiring the new skills and knowledge is important.
Adult learners need constructive feedback to develop and are motivated to learn through intrinsic and extrinsic motivation.

Adult learners have a tendency towards self-directed learning and learn best when they can set their own pace. They need to decide for themselves what they want to learn.

Adults learn more effectively through experiential techniques (i.e. discussion, problem solving and hands on practicing). They have a task centred orientation to learning.

(Cited in HETI Superguide 2012)

It is widely recognised that the methods used to teach children are, in most cases, not the most effective methods for teaching adults. The difference between the teaching of adults and the teaching of children is referred to as andragogy and pedagogy.

Andragogy refers to the art of teaching adults, whereas Pedagogy literally means "leading children".

<table>
<thead>
<tr>
<th>Andragogy</th>
<th>Pedagogy</th>
</tr>
</thead>
<tbody>
<tr>
<td>The learner is self-directed and responsible for his/her own learning</td>
<td>The learner is dependent upon the instructor for all learning</td>
</tr>
<tr>
<td>Self-evaluation is performed by the learner to assess gaps between where one is now and where one wants and needs to be</td>
<td>The instructor assumes full responsibility for what is taught and how it is learnt</td>
</tr>
<tr>
<td>The learner brings a greater volume and quality of experience and are a rich resource for one another</td>
<td>The instructor evaluates the learning and modifies accordingly</td>
</tr>
<tr>
<td>Different experiences assure diversity in groups of adults</td>
<td>The learner comes with little experience that could be tapped as a resource for learning</td>
</tr>
<tr>
<td>Learning must have relevance to real-life tasks</td>
<td>The experience of the instructor is the most influential</td>
</tr>
<tr>
<td>Learning is organized around life/work situations rather than</td>
<td>Students are told what they have to learn in order to</td>
</tr>
</tbody>
</table>
There are internal motivators: self-esteem, recognition, better quality of life, self-confidence, self-actualization.

Learning is a process of acquiring prescribed subject matter.

(Rachel 1994)

**Adult Learning Styles**

People take in and process information by seeing and hearing it, reflecting and acting on it, reasoning logically and intuitively about it and analysing and visualizing it in different ways. These different ways relate to the different learning styles that people have which are “characteristic cognitive, affective, and psychological behaviours that serve as relatively stable indicators of how learners perceive, interact with, and respond to the learning environment” (Keefe, 1979).

The overall aim for an instructor or supervisor should be to equip students with the skills associated with every learning style, regardless of the students’ personal preferences, since they will need all of those skills to function effectively as professionals.

There are many models that have been developed to assist with identifying adult learning styles, although the most widely known models are the Myer Briggs Type Indicator (MBTI), Kolb’s Learning Style Inventory, Honey and Mumford, and Felder and Silverman.

It is important to remember that a learning style describes how we learn, not how well we learn.

**Myer Briggs Type Indicator (MBTI)**

The theory of different psychological types was introduced in the 1920s by Carl G. Jung. Isabel Briggs Myers then developed the MBTI in the 1940’s to make Jung’s theories more useful and understandable. The purpose of knowing about personality types is to better recognise and appreciate the differences between people. There is no better personality, all types are equal, and the MBTI indicates preferences, not traits, ability or character (MBTI 2013) and so it offers an insight into how your supervisee might prefer to learn, and perhaps how to best to interact with each other.

There are 16 different personality types that come from the basic preferences of four different dichotomies. Individuals decide which preferences best relate to them from each of the 4 tables below. By noting the letter of each of the preferences the individual will have a 4 letter ‘code’, these letters will indicate the personality type.

It is important to remember that not every statement will relate to the individual, but most people will find more preferences in one column than they do the other.

We often teach based on our styles of learning and preferences and so it is also useful to know your personality type and preferences to see how they differ to that of your learner. It
may give you more of an understanding and an insight into the characters and mannerisms of your supervisees.

*Take the Myer Briggs Type Inventory...*

<table>
<thead>
<tr>
<th>Extraversion (E)</th>
<th>Introversion (I)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefer to focus on the outer world</td>
<td>Prefer to focus on the inner world</td>
</tr>
<tr>
<td>Like to get energy from active involvement in events</td>
<td>Like getting energy from ideas, pictures, memories and reactions that are inside my head</td>
</tr>
<tr>
<td>Like having lots of different activities</td>
<td>Prefer doing things alone or with 1-2 people</td>
</tr>
<tr>
<td>Excited when around people and like to energise other people</td>
<td>I take time to reflect so that I have a clear idea of what I’ll be doing</td>
</tr>
<tr>
<td>Like to make things happen</td>
<td>Ideas are almost solid things for me</td>
</tr>
<tr>
<td>Understand problems better by talking out loud and hearing what others have to say</td>
<td>Sometimes I like the idea of something better than the real thing</td>
</tr>
<tr>
<td>Statements that apply to me:</td>
<td>Statements that apply to me:</td>
</tr>
<tr>
<td>• Feel comfortable and like working in groups</td>
<td>• I am seen as “reflective” or “reserved.”</td>
</tr>
<tr>
<td>• I am outgoing, a people person</td>
<td>• I prefer to know just a few people well.</td>
</tr>
<tr>
<td>• I have a wide range of friends and know lots of people</td>
<td>• I feel comfortable being alone and like things I can do on my own</td>
</tr>
<tr>
<td>• I sometimes jump too quickly into an activity and don’t allow time to think it over</td>
<td>• I sometimes spend too much time reflecting and don’t move into action quickly enough</td>
</tr>
<tr>
<td>• I sometimes forget to stop and get clear on what I want to do and why</td>
<td>• I sometimes forget to check with the outside world to see if my ideas really fit the experience</td>
</tr>
</tbody>
</table>

**Are you an (E) or (I)?**
<table>
<thead>
<tr>
<th>Sensing (S)</th>
<th>Intuition (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefer to focus on the basic information you take in</td>
<td>Prefer to interpret and add meaning</td>
</tr>
<tr>
<td>Pay attention to physical reality; what you see, hear, touch and smell</td>
<td>Pay most attention to impressions or meanings of patterns</td>
</tr>
<tr>
<td>Are concerned with what is actual, present, current and real</td>
<td>Would rather learn by thinking problems through, as opposed to hands on experience</td>
</tr>
<tr>
<td>Notice facts and remember details that are important to you</td>
<td>Interested in new things and what might be possible</td>
</tr>
<tr>
<td>Like to see the practical use of things</td>
<td>Think more about the future than the past</td>
</tr>
<tr>
<td>Learn best when you see how to use what you are learning</td>
<td>Like to work with symbols or abstract theories</td>
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<tr>
<td>Experience speaks louder than words</td>
<td>Remember events more as an impression of what it was like than the facts of what actually happened</td>
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**Statements that apply to me:**

- I remember events as snapshots
- I solve problems by working through the facts
- I am pragmatic and look at the bottom line
- I start with the facts to form a big picture
- I trust experience first, and words and symbols less
- Sometimes I pay so much attention to the facts that I miss new possibilities

**Statements that apply to me:**

- I remember events by what I read between the line about their meaning
- I solve problems by leaping between different ideas and possibilities
- I am interested in doing things that are new or different
- I like to see the big picture then find out the facts
- I trust impressions, symbols, and metaphors more than what I actually experienced
- Sometimes I think so much about new possibilities that I never look at how to make them a reality

*Are you a (S) or (N)?*
### Thinking (T)
- Prefer to first look at logic and consistency
- When making a decision - like to find the basic truth or principle
- Like to analyse the pro’s and con’s and then be consistent and logical in deciding
- Try to be impersonal, not let personal wishes, or other people’s personal wishes influence me

**Statements that apply to me:**
- I remember events as snapshots
- I solve problems by working through the facts
- I am pragmatic and look at the bottom line
- I start with the facts to form a big picture
- I trust experience first, and words and symbols less
- Sometimes I pay so much attention to the facts that I miss new possibilities

### Feeling (F)
- Prefer to first look at people and special circumstances
- Make the best decisions by weighing what people care about and the points-of-view of persons involved in a situation
- Concerned with values and what is best for the people involved
- Like to do whatever will establish or maintain harmony

**Statements that apply to me:**
- I have a people or communications orientation
- I am concerned with harmony and get nervous when it missing
- I look for what is important to others and express concern for others
- I make decisions with my heart and want to be compassionate
- I believe being tactful is more important than telling the ‘cold’ truth
- Sometimes I miss seeing the truth of situations
- I am sometimes described as idealistic, indirect
- I appear caring, warm, and tactful

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*Are you a (T) or (F)?
| Judging (J)  
(Not in the judgemental sense) | Perceiving (P)  
(Taking in new info, not perceptions of...) |
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<tr>
<td>Prefer to get things decided</td>
<td>Prefer to stay open to new information and options</td>
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<td>Like a planned or orderly way of life, to have things settled and organised</td>
<td>Like a flexible and spontaneous way of life</td>
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<td>Feel more comfortable when decisions are made</td>
<td>Like to understand and adapt to the world rather than organise it</td>
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<tr>
<td>Like to bring life under control as much as possible</td>
<td>Others see me as staying open to new experiences and information</td>
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<tr>
<td>Inside, I feel flexible and open to new information</td>
<td>Inside, I feel very planful and decisive</td>
</tr>
<tr>
<td><strong>Statements that apply to me:</strong></td>
<td><strong>Statements that apply to me:</strong></td>
</tr>
<tr>
<td>• I like to have things decided</td>
<td>• I like to stay open to respond to whatever happens</td>
</tr>
<tr>
<td>• I appear to be task oriented</td>
<td>• I appear to be loose and casual. I like to keep plans to a minimum</td>
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<tr>
<td>• I like to make lists of things to do</td>
<td>• I like to approach work as play or mix work and play</td>
</tr>
<tr>
<td>• I like to get my work done before playing.</td>
<td>• I work in bursts of energy</td>
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<tr>
<td>• I plan work to avoid rushing just before a deadline</td>
<td>• I am stimulated by an approaching deadline</td>
</tr>
<tr>
<td>• Sometimes I focus so much on the goal that I miss new information</td>
<td>• Sometimes I stay open to new information so long that I miss making decisions when they are needed</td>
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Are you a (J) or (P)?
The 16 Personality Types

What are your 4 letters? _____________

**ISFJ** - Quiet, friendly, responsible, and conscientious. Committed and steady in meeting their obligations. Thorough, painstaking, and accurate. Loyal, considerate, notice and remember specifics about people who are important to them, concerned with how others feel. Strive to create an orderly and harmonious environment at work and at home.

**ISTJ** - Quiet, serious, earn success by thoroughness and dependability. Practical, matter-of-fact, realistic, and responsible. Decide logically what should be done and work toward it steadily, regardless of distractions. Take pleasure in making everything orderly and organized – their work, their home, their life. Value traditions and loyalty.

**ISTP** - Tolerant and flexible, quiet observers until a problem appears, then act quickly to find workable solutions. Analyse what makes things work and readily get through large amounts of data to isolate the core of practical problems. Interested in cause and effect, organize facts using logical principles, value efficiency.

**ISFP** - Quiet, friendly, sensitive, and kind. Enjoy the present moment, what’s going on around them. Like to have their own space and to work within their own time frame. Loyal and committed to their values and to people who are important to them. Dislike disagreements and conflicts; do not force their opinions or values on others.
**INTJ** - Have original minds and great drive for implementing their ideas and achieving their goals. Quickly see patterns in external events and develop long-range explanatory perspectives. When committed, organize a job and carry it through. Sceptical and independent, have high standards of competence and performance – for themselves and others.

**INFJ** - Seek meaning and connection in ideas, relationships, and material possessions. Want to understand what motivates people and are insightful about others. Conscientious and committed to their firm values. Develop a clear vision about how best to serve the common good. Organized and decisive in implementing their vision.

**INFP** - Idealistic, loyal to their values and to people who are important to them. Want an external life that is congruent with their values. Curious, quick to see possibilities, can be catalysts for implementing ideas. Seek to understand people and to help them fulfill their potential. Adaptable, flexible, and accepting unless a value is threatened.

**INTP** - Seek to develop logical explanations for everything that interests them. Theoretical and abstract, interested more in ideas than in social interaction. Quiet, contained, flexible, and adaptable. Have unusual ability to focus in depth to solve problems in their area of interest. Sceptical, sometimes critical, always analytical.
ENFP - Warmly enthusiastic and imaginative. See life as full of possibilities. Make connections between events and information very quickly, and confidently proceed based on the patterns they see. Want a lot of affirmation from others, and readily give appreciation and support. Spontaneous and flexible, often rely on their ability to improvise.

ESTP - Flexible and tolerant, they take a pragmatic approach focused on immediate results. Theories and conceptual explanations bore them – they want to act energetically to solve the problem. Focus on the here-and-now, spontaneous, enjoy each moment that they can be active with others. Enjoy material comforts and style. Learn best through doing.

ESFJ - Warm-hearted, conscientious, and cooperative. Want harmony in their environment; work with determination to establish it. Like to work with others to complete tasks accurately and on time. Loyal, follow through even in small matters. Notice what others need in their day-by-day lives and try to provide it. Want to be appreciated for who they are and for what they contribute.

ESFP - Outgoing, friendly, and accepting. Exuberant lovers of life, people, and material comforts. Enjoy working with others to make things happen. Bring common sense and a realistic approach to their work, and make work fun. Flexible and spontaneous, adapt readily to new people and environments. Learn best by trying a new skill with other people.
**ESTJ** - Practical, realistic, matter-of-fact. Decisive, quickly move to implement decisions. Organize projects and people to get things done, focus on getting results in the most efficient way possible. Take care of routine details. Have a clear set of logical standards, systematically follow them and want others to also. Forceful in implementing their plans.

**ENTP** - Quick, ingenious, stimulating, alert, and outspoken. Resourceful in solving new and challenging problems. Adept at generating conceptual possibilities and then analysing them strategically. Good at reading other people. Bored by routine, will seldom do the same thing the same way, apt to turn to one new interest after another.

**ENTJ** - Frank, decisive, assume leadership readily. Quickly see illogical and inefficient procedures and policies, develop and implement comprehensive systems to solve organizational problems. Enjoy long-term planning and goal setting. Usually well informed, well read; enjoy expanding their knowledge and passing it on to others. Forceful in presenting their ideas.

**ENFJ** - Warm, empathetic, responsive, and responsible. Highly attuned to the emotions, needs, and motivations of others. Find potential in everyone; want to help others fulfil their potential. May act as catalysts for individual and group growth. Loyal, responsive to praise and criticism. Sociable, facilitate others in a group, and provide inspiring leadership.

(Myer Briggs 2003)
**Felder and Silverman’s Model**

The model developed by Felder and Silverman (1988) assess an individual’s learning style by asking 4 questions:

1. **What type of information does the student preferentially perceive?**
   - **sensory**
     - (sights, sounds, physical sensations)
     - Sensory learners tend to be concrete, practical, methodical, and oriented toward facts and hands-on procedures
   - **Intuitive**
     - (memories, thoughts, insights)
     - Intuitive learners are more comfortable with abstractions (theories, mathematical models) and are more likely to be rapid and innovative problem solvers

2. **What type of sensory information is most effectively perceived?**
   - **Visual**
     - (pictures, diagrams, flow charts, demonstrations)
   - **Verbal**
     - (written and spoken explanations)

3. **How does the student prefer to process information?**
   - **Actively**
     - (through engagement in physical activity or discussion)
   - **Reflectively**
     - (through introspection and thinking)

4. **How does the student characteristically progress toward understanding?**
   - **Sequentially**
     - (in a logical progression of incremental steps)
     - Sequential learners are able to function with only partial understanding of material they have been taught
   - **Globally**
     - (in large “big picture” jumps)
     - Global learners may have trouble applying new material until they fully understand it

(Felder and Silverman 1988)
**Kolb’s Learning Style Inventory**

Kolb’s experiential learning style theory is represented by a four stage learning cycle in which a person progresses through the four stages:

- **Concrete Experience** - (a new experience is encountered, or an existing experience is reinterpreted).
- **Reflective Observation** (of the new experience, and attempts to identify any inconsistencies between experience and understanding).
- **Abstract Conceptualization** (Reflection gives rise to a new idea, or a modification of an existing abstract concept).
- **Active Experimentation** (the learner applies them to the world around them to try out what they have learnt).

Kolb (1984) views learning as an integrated process with each stage being mutually supportive of and leading into the next. It is possible to enter the cycle at any stage and follow it through its logical sequence, although no one stage of the cycle is effective for learning on its own. So for effective learning to occur all four stages of the cycle must be completed.

Kolb’s Leaning Style inventory gives individuals an idea of how they learn. It takes approximately 30 minutes to complete the inventory and ascertain the learning style profile.
1. For the words in each row in the table below, rank the words as to how best they suit your learning style in order of:

4 to the word which best characterises your learning style
3 to the next best,
2 to the next,
1 to the least characteristic word

| 1. _____ involved | _____ tentative | _____ discriminating | _____ practical |
| 2. _____ receptive | _____ impartial | _____ analytical | _____ relevant |
| 3. _____ feeling | _____ watching | _____ thinking | _____ doing |
| 4. _____ accepting | _____ aware | _____ evaluating | _____ risk-taker |
| 5. _____ intuitive | _____ questioning | _____ logical | _____ productive |
| 6. _____ concrete | _____ observing | _____ abstract | _____ active |
| 7. _____ present-oriented | _____ reflecting | _____ future-oriented | _____ practical |
| 8. _____ open to new experiences | _____ perceptive | _____ intelligent | _____ competent |
| 9. _____ experience | _____ observation | _____ conceptualization | _____ experimentation |
| 10. _____ intense | _____ reserve | _____ rational | _____ responsible |

Add the numbers down each column

_____ (CE) _____ (RO) _____ (AC) _____ (AE)
The sum of the first column gives you your score on **CE: Concrete Experience**; the second column gives you your score on **RO: Reflective Observation**; your score on the third column is for **AC: Abstract Conceptualization**; and the fourth column is your score on **AE: Active Experimentation**.

Transfer each of your scores to the Learning Style Profile below by placing a mark by the number you scores on each of the four dimensions. Connect these four marks with straight lines.
**Interpretation:**

Your *individual scores* provide a relative emphasis you give to each of the four different stages of learning. Kolb (1984) defines each stage as follows:

**Concrete Experience (CE)** focuses on being involved in experiences and dealing with immediate human situations in a personal way. It emphasizes feeling more than thinking; a concern with the uniqueness and complexity of present reality over theories and generalizations; and intuitive, "artistic" approach over a systematic, scientific approach to problems.

**Reflective Observation (RO)** focuses on understanding the meaning of ideas and situations by carefully observing and describing them. It emphasizes reflection and understanding over action and practical application; a concern with what is true or how things happen over what will work.

**Abstract Conceptualization (AC)** focuses on using logic, ideas, and concepts. It emphasizes thinking rather than feeling; a concern with building general theories rather than intuitively understanding unique, specific areas; a scientific more than an artistic approach to problems.

**Active Experimentation (AE)** focuses on actively influencing people and changing situations. It emphasizes practical applications as distinct from reflective understanding; a pragmatic concern with what works rather than with what is absolute truth; an emphasis on doing, more than observing.

How you resolve the tensions between conceptualisation and experience and between action and reflection is your dominant learning style. The quadrant with the largest enclosed space on the Learning style profile, labelled in red text is your dominant learning style.

**Convergent** learning style relies primarily on the dominant learning abilities of abstract conceptualization and active experimentation. The greatest strength of this approach lies in problem solving, decision-making, and the practical application of ideas. The style works best in situations where there is a single correct answer or solution to a question or problem. The style suggests a preference for task accomplishment or productivity rather than for more socio-emotional experiences.
**Divergent** learning style has the opposite learning strengths from the convergent. It emphasizes concrete experience and reflective observation. Its greatest strength lies in imaginative ability and awareness of meaning and values. The primary adaptive ability of divergence is to view concrete situations from many perspectives and to organize many relationships into a meaningful “gestalt”. The emphasis in this style is on adaptation by observation rather than action. It is called divergent because it works best in situations that call for generation of alternative ideas and implications, such as “brainstorming” ideas. The style suggests a preference for socio-emotional experiences over task accomplishment.

**Assimilative** learning abilities are abstract conceptualization and reflective observation. The greatest strength of this style lies in inductive reasoning and the ability to create theoretical models, in assimilating disparate observations into an integrated explanation. As in convergence, this orientation is focused less on socio-emotional interactions and more on ideas and abstract concepts. Ideas are valued more for being logically sound and precise than for their practical values. It is more important that the theory be logically sound and precise.

**Accommodative** learning style has the opposite strengths from assimilation, emphasizing concrete experience and active experimentation. The greatest strength of this style lies in doing things, in carrying out plans and tasks and getting involved in new experiences. The adaptive emphasis of this orientation is on opportunity seeking, risk taking and action. This style is called accommodative because it is best suited for those situations where one must adapt oneself to changing immediate circumstances. In situations where the theory or plans do not fit the facts, those with an accommodative style will most likely discard the plan or theory.

(Kolb 1984)
Honey and Mumford's Model

Honey and Mumford believe that most people have never consciously considered how they learn and so developed the Learning Styles Questionnaire (LSQ) which probes general behavioural tendencies. They also suggest that people prefer different methods of learning, depending upon the situation and their experience level, thus they move between the four styles of learning, rather than being dominantly locked into one style. Their model is derived from Kolb's, although differs in that learners can move around the cycle in no particular logic or sequence.

Learning Styles Questionnaire

Complete the below questionnaire by placing a tick by the statements you agree with most, and a cross by the statements you disagree with most.

1. I like to be absolutely correct about things.
2. I quite like to take risks.
3. I prefer to solve problems using a step by step approach rather than guessing.
4. I prefer simple, straightforward things rather than something complicated.
5. I often do things just because I feel like it rather than thinking about it first.
6. I don't often take things for granted. I like to check things out for myself.
7. What matters most about what you learn is whether it works in practice.
8. I actively seek out new things to do.
9. When I hear about a new idea I immediately start working out how I can try it out.
10. I am quite keen on sticking to fixed routines, keeping to timetables, etc.
11. I take great care in working things out. I don't like jumping to conclusions.
12. I like to make decisions very carefully and preferably after weighing up all the other possibilities first.
13. I don't like 'loose ends'; I prefer to see things fit into some sort of pattern.
14. In discussions I like to get straight to the point.
15. I like the challenge of trying something new and different.
16. I prefer to think things through before coming to a conclusion.
17. I find it difficult to come up with wild ideas off the top of my head.
18. I prefer to have as many bits of information about a subject as possible, the more I have to sift through the better.
19. I prefer to jump in and do things as they come along rather than plan things out in advance.
20. I tend to judge other people's ideas on how they work in practice.
21. I don't think that you can make a decision just because something feels right. You have to think about all the facts.
22. I am rather fussy about how I do things - a bit of a perfectionist.
23. In discussions I usually pitch in with lots of ideas.
24. In discussions I put forward ideas that I know will work.
25. I prefer to look at problems from as many different angles as I can before starting on them.
26. Usually I talk more than I listen.
27. Quite often I can work out more practical ways of doing things.
28. I believe that careful logical thinking is the key to getting things done.
29. If I have to write a formal letter I prefer to try out several rough workings before writing out the final version.
30. I like to consider all the alternatives before making my mind up.
31. I don't like wild ideas. They are not very practical.
32. It is best to look before you leap.
33. I usually do more listening than talking.
34. It doesn't matter how you do something, as long as it works.
35. I can't be bothered with rules and plans; they take all the fun out of things.
36. I'm usually the 'life and soul' of the party.
37. I do whatever I need to do, to get the job done.
38. I like to find out how things work.
39. I like meetings or discussion to follow a proper pattern and to keep to a timetable.
40. I don't mind in the least if things get a bit out of hand.

Look at the question numbers that you have ticked and put ‘1’ next to the number below.

Add the ‘1’s in each column.

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<th>Theorist</th>
<th>Pragmatist</th>
<th>Activist</th>
<th>Reflector</th>
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The highest score of all 4 descriptors highlights your preferred learning style.
Reflective - Prefers to learn from activities that allow them to watch, think, and review (time to think things over) what has happened. Like to use journals and brainstorming. Lectures are helpful if they provide expert explanations and analysis.

Theorist - Prefer to think problems through in a step-by-step manner. Likes lectures, analogies, systems, case studies, models, and readings. Talking with experts is normally not helpful.

Pragmatist - Prefer to apply new learning’s to actual practice to see if they work. Likes laboratories, field work, and observations. Likes feedback, coaching, and obvious links between the task-on-hand and a problem.

Activist - Prefer the challenges of new experiences, involvement with others, assimilation and role-playing. Likes anything new, problem solving, and small group discussions.

(Honey and Mumford 2000)
Important Aspects of Clinical Supervision

Safety
Creating a safe learning environment is not just about ensuring that there is a physically safe place to learn (Hutchinson, 2003), and maintaining safety for the patient. Learning can be emotionally and psychologically challenging, as individuals may be required to question their existing knowledge, at times in front of peers, which may provoke feelings of anxiety, degradation and humiliation if not facilitated properly and safely. Facilitators should use methods such as constructive feedback, effective debriefing and encouragement of reflection to create safe environments.

Confidentiality
Confidentiality is crucial to supervision and what is discussed should remain between the supervisor and supervisee. However, health professionals have a legal duty of care that may over ride confidentiality in exceptional circumstances. Such circumstances would be if the supervisee is describing unsafe, unethical or illegal practice and is unwilling to go through appropriate procedures to address these after initial discussion between supervisor/supervisee.

Documentation
A formal agreement outlining the clinical supervision arrangement should be discussed and documented. This is sometimes referred to as a learning contract. The documentation should include:

- The supervisor’s and supervisee’s names
- Expectations from each other
- Details about the model of supervision
  - Format – individual, group or peer
  - Mode – face to face, online, via videoconferencing
  - Frequency – daily, weekly, monthly
  - Venue – an appropriate quiet, private space
- How goals will be achieved
- Timeframe for achievement

Ongoing documentation of formal supervisory meetings should also be maintained. Supervision records are legal documents and in the context of misconduct or legal proceedings arising out of adverse events may be used as evidence. Supervision notes must be objective and accurately maintained according to NSW Health standards and stored for a period of time in line with NSW Government State Record Requirements www.records.nsw.gov.au.

(HETI Superguide 2012)
Models of Supervision

There are a number of different functions that make up clinical supervision. Kadushin’s model of supervision outlined three functions; educational, supportive and administrative (Kadushin 1976). These functions have been further defined by Proctor (1987) as formative, restorative and normative, describing them in terms of an interactive framework for clinical supervision, suggesting that all three functions should be overlapping and flexible (Driscoll 2007).

**Educational (Formative)** – involves the development of each worker in a manner that enhances their full potential by

- providing knowledge and skills
- developing self-awareness
- reflecting on practice
- integrating theory into practice
- facilitating professional reasoning
- identifying professional development needs
- understanding the supervisee better
- exploring other ways of working

**Supportive (Restorative)** – maintains the harmonious working relationships with a focus on morale and job satisfaction by:

- dealing with job-related stress
- sustaining worker morale
- developing a sense of professional self-worth
- exploring the emotional reaction to pain, conflict and other feelings experienced during patient care
- providing counsel regarding clinical cases
- exploring responses in particular scenarios

**Administrative (Normative)** – promotes and maintains good standards of work, including ethical practice, accountability measures and adherence to policies of administration by:

- clarifying roles and responsibilities
- managing work load
- reviewing and assessing work
- addressing organisation, practice and quality control issues
- ensuring supervisee’s reach appropriate professional standards
- evaluating and monitoring professional ethical issues

(Cited in HETI Superguide 2012)
Developing Learning Goals & Objectives

Although certain clinical areas, and supervisee’s coming from academic institutions may already have specific learning objectives, many supervisees will need to develop their own learning goals detailing what they need to work towards. It is important that the educational objectives and goals reflect the activities and the clinical context in which the supervisee can practice.

Documenting these goals also provides a framework or reference for reviewing progress during formal supervision meetings. The supervision records should be reviewed and updated with the acquisition of skills and knowledge as the supervisee develops.

Learning goals should be SMART: i.e., they should be Specific, Measurable, Achievable, Realistic and Timely (Doran 1981).

**Specific** Goal must be well defined, clear and unambiguous.
- What do you want to accomplish?
- Why?
- Who will be involved?
- Where will it occur?

**Measurable** Define a criterion for measuring progress toward the goal.
- How much?
- How many?
- How will you know when you have reached your goal?

**Achievable** Goal must be achievable.
- How will your goal be achieved?
- What are some of the constraints you may face when achieving this goal?

**Realistic** Goal needs to be relevant.
- How does the goal fit with your immediate and long term plan?
- How is it consistent with other goals you have?

**Timely** goal should be grounded within a timeframe.
- What can you do in 6 months from now?
- What can you do in 6 weeks from now?
- What can you do today?

(HETI Superguide 2012)
**The Cycle of Learning**

In the learning cycle, learners move through four stages in the acquisition of particular competencies, from unconsciously incompetent to unconsciously competent.

1. **Unconscious Incompetence** - The learner does not actually know all the steps that have to be carried out, but ironically they may feel quite capable of carrying out the procedure.

2. **Conscious Incompetence** – While trying to perform a specific technique themselves they realise it is perhaps not as easy as it appeared, they become consciously incompetent and, providing the motivation is high enough, try to learn all the steps involved.

3. **Conscious Competence** – Once the learner understands and can carry out the various steps of a skill or technique, they still have to think about the procedure, but given time, they will be able to carry it out confidently and competently.

4. **Unconscious Competence** – With practice the learner enters this step having mastered the technique, implying that they can carry out the procedure or the knowledge without consciously having to think about it (it becomes routine).

(Peyton 1998)
Teaching Clinical Skills

One way of teaching skills and developing supervisees to a competent level is using the four step method. It ensures that the instructor breaks down the process into manageable steps, asks the learner to vocalize the steps, and provides repetition to reinforce the learning and correct mistakes.

1. **Demonstration.** Trainer demonstrates at normal speed without commentary.
2. **Deconstruction.** Trainer demonstrates while describing steps.
3. **Comprehension.** Trainer demonstrates while learner describes steps.
4. **Performance.** Learner demonstrates while learner describes steps.

(Peyton 1998)

Other ways of teaching clinical skills include:

- Demonstrating clinical skills while providing hands-on care for patients in the presence of learners and discussing what is being done.
- Linking theory and practice by explaining the logic and the evidence behind the practice.
- Providing opportunities to practice skills by making time and space available for the learner to be hands-on, breaking procedures into steps, providing direction, sharing care.
- Collaborative problem solving by giving learners a clinical problem and working with them towards a solution.
- The Socratic Method which involves asking questions to discover the level of knowledge and to encourage independent thinking and problem-solving. Effective questioning reveals what it is that really needs to be taught, uncovers misunderstandings, and reinforces and extends existing knowledge. Questions keep trainees engaged, “on their toes”, listening and thinking. One proviso: don’t use questions to “prosecute” or humiliate the learner, or to show off your own expansive knowledge, which creates an unsafe environment for the learner.
- Individualising learning which is only possible if you begin by asking questions. Teaching is more effective if it is tailored to the learner’s interests, ambitions and current level of knowledge and ability.
- Giving feedback that is timely, specific, and constructive and given in an appropriate environment.

(The Superguide 2010)
Providing Clinical Supervision

Clinical supervision can be provided in many different forms and methods over differing time frames. For example students might be supervised for as little as a week, or new graduate staff may be ‘mentored’ for 6 months or more. These factors will determine the methods of clinical supervision that you use.

**Day-to-day supervision** – is where the learner has direct access to their supervisor to facilitate the delivery of patient care. Also known as “informal” supervision, it can occur face to face, over the phone or even remotely via email. In addition, the supervisor may provide physical or “hands on” assistance if required to build clinician confidence and to support the delivery of safe patient care.

**One-to-one structured supervision** - conducted regularly, as determined by local supervision policies or professional practice requirements. The supervision session time should be protected and prioritised by both the supervisee and the supervisor. Supervision should be conducted in an appropriate environment that facilitates patient care/case discussion, reflective practice, and the setting and monitoring of learning goals and objectives.

**Group supervision** - the purpose of group supervision is to provide a forum for facilitated open discussion and learning from each other’s experiences. This may include clinical case discussions, topics of interest, interprofessional collaboration and team work. Group supervision is led by a clinical supervisor and can be conducted face to face or via the use of online technology.

**Peer supervision** - is usually conducted between two or more experienced health professionals as a method of consultation, problem solving, reflective practice and clinical decision making. It provides a forum for sharing of knowledge and experience and is used to complement more formal avenues of supervision and develop supervisory abilities.
From a supervisor’s point of view, both hands-on and hands-off supervision are active processes, requiring the exercise of judgment. How far along the trajectory of development is the learner? When is it time to intervene? Hands-off supervision is not absence of supervision. In general, learners need more hands-on supervision at the beginning, an intermediate period of being able to shift back and forth and the increasing amounts of hands-off supervision as they develop.

- “Hands-on” supervision — interactions with clinicians who are expert in areas where they need help
- “Hands-off” supervision — being trusted to act independently, being given space to deploy their nascent skills and test their growing clinical abilities.

(From The Superguide 2010)

Reflection

Reflection is a means of constructing knowledge from actions or experience and has been described in two ways; reflection in action and reflection on action. Reflection on action is looking back after the event whilst reflection in action is happening during the event. (Schon 1987).

Reflection can be on a positive experience or action where something went well or a negative one where you need to think about what has happened. Reflection includes identifying strengths and weaknesses, determining the actions required to improve skills and developing clinical reasoning skills to ensure the delivery of safe patient care.

Reflective practice is an effective process to develop self-awareness and facilitate changes in professional behaviour. Reflection can occur before, during or after an event (Sandars 2009).

When reflection occurs in supervision, it can be in relation to reflecting on day to day clinical practice, triggered by a challenging clinical encounter or in anticipation of having to manage a complex situation. It is imperative that reflective practice is conducted in a supportive environment to allow individuals to freely share information that promotes learning.

Examples of how reflective practice is conducted include:

- During structured supervision sessions the supervisee provides the supervisor with an overview of an issue or incident and the supervisor uses questioning to encourage reflection on its meaning (see examples below).
- Reflective journal/record keeping is a self-directed activity, where the clinician is guided by a template of key questions to record their experiences, work through the issues and reflect on their learning. They can then use this as a tool for discussion with their supervisor or to keep as a record of continuing professional development.
Reflection should be undertaken by all health professionals, including the supervisory capacity. There are many models of reflective practice that can be used in supervision, for the supervisor and the supervisee. Below are just a couple of useful ones.

**Gibbs’ model of reflection (1988)**

![Gibbs' model of reflection diagram]

**Step 1: Description of the event** - Describe in detail the event you are reflecting on.

Include e.g. where were you; who else was there; why were you there; what were you doing; what were other people doing; what was the context of the event; what happened; what was your part in this; what parts did the other people play; what was the result.

**Stage 2: Feelings and Thoughts (Self-awareness)** - At this stage, try to recall and explore those things that were going on inside your head. Include:

- How you were feeling when the event started?
- What you were thinking about at the time?
- How did it make you feel?
- How did other people make you feel?
- How did you feel about the outcome of the event?
- What do you think about it now?

**Stage 3: Evaluation** - Try to evaluate or make a judgement about what has happened. Consider what was good about the experience and what was bad about the experience or what did or didn’t go so well.
**Stage 4: Analysis** - Try to break the event down into its component parts so it can be explored separately. You may need to ask more detailed questions about the answers to the last stage. Include:

- What went well?
- What did you do well?
- What did others do well?
- What went wrong or did not turn out how it should have done?
- In what way did you or others contribute to this?

**Stage 5: Conclusion (Synthesis)**
This differs from the evaluation stage in that now you have explored the issue from different angles and have a lot of information to base your judgement. It is here that you are likely to develop insight into your own and other people’s behaviour in terms of how they contributed to the outcome of the event. Remember the purpose of reflection is to learn from an experience. Without detailed analysis and honest exploration that occurs during all the previous stages, it is unlikely that all aspects of the event will be taken into account and therefore valuable opportunities for learning can be missed.

**Stage 6: Action Plan**
During this stage you should think yourself forward into encountering the event again and to plan what you would do – would you act differently or would you be likely to do the same? Here the cycle is tentatively completed and suggests that should the event occur again it will be the focus of another reflective cycle.

**Johns’ Model of Reflection**
This model provides cues to help the clinician access, make sense of, and learn through the experience.

**Description**
Write a description of the experience, what are the key issues within this description that I need to pay attention to?

**Reflection**
- What was I trying to achieve?
- Why did I act as I did?
What are the consequences of my actions?
  - For the patient and family
  - For myself
  - For people I work with

How did I feel about this experience when it was happening?
How did the patient feel about it?
How do I know how the patient felt about it?

**Influencing factors**

- What internal factors influenced my decision-making and actions?
- What external factors influenced my decision-making and actions?
- What sources of knowledge did or should have influenced my decision making and actions?

**Alternative strategies**

- Could I have dealt better with the situation?
- What other choices did I have?
- What would be the consequences of these other choices?

**Learning**

- How can I make sense of this experience in light of past experience and future practice?
- How do I NOW feel about this experience?
- Have I taken effective action to support myself and others as a result of this experience?
- How has this experience changed my way of knowing in practice?

(Johns 1994)
Providing Feedback

Feedback is an essential component of supervision and must be clear so that the staff member is aware of their strengths and weaknesses and how they can improve (Kilminster & Jolly 2000). Feedback is critical to the learning cycle and when the type, amount and timing of the feedback is appropriate it can be effective and constructive. If it is given inappropriately it can have negative impacts on the learner’s performance.

A useful way to ‘start the conversation’ when giving feedback to individuals or groups is to begin by discussing what they think they did well, and then move on to what they think can be improved. This provides the opportunity to hear from the learner first and gauge how much self-reflection has occurred as part of the learning experience. The facilitator can then add other thoughts, and then the learner can reflect on areas of improvement.

- **Timing** - Give feedback as soon as possible and align feedback with the learning objectives. However, pick a good moment for feedback (not when you or the supervisee is exhausted, distracted or upset). Feedback on performance should be part of an overall communication approach in the supervisory relationship.

- **Be Clear** - Vague or generalised praise or criticism is difficult to act upon. Be specific, adopt a straightforward manner, and give examples where possible. Comment on the performance or behaviour, not the person, and focus on the here and now and try to make objective rather than subjective comments.

- **Be Constructive** - Focus on the positive and avoid dampening positive feedback by qualifying it with a negative statement (“I was very happy with your presentation, but …”). For criticism, talk in terms of what can be improved, rather than what is wrong. Try to provide feedback in the form of solutions and advice. At the same time, if the supervisee makes an error, feedback needs to be unambiguous (“You didn’t use the correct technique for tying that knot. Next time …” Find at least one positive comment to make in situations where performance was poor and collaboratively explore strategies to overcome the concerns raised in the feedback session.

- **Be in an appropriate setting** - Positive feedback can be effective when given in the presence of peers or patients. Negative feedback (constructive criticism) should be given in a private and undisturbed setting.

- **Listen and Respond** - Learner’s must be given the opportunity to comment on the feedback and to provide explanations for their performance. A feedback session should be a discussion that leads to improvement, not a ‘reprimanding’ session. Be aware and address signs where feedback is
rejected e.g. providing excuses, not paying attention, criticising and questioning the validity of the source and defensive body language.

If feedback is not given appropriately there are numerous consequences:

- Clinical care is not as good as it could be
- Anxieties and inadequacies are not addressed
- Weaknesses may be exposed later in their career because the staff member has difficulty accepting criticism because of previous “good reports”
- Others are blamed when the staff member is unsuccessful
- Learning is inhibited, career progression is delayed
- Staff are not given the opportunity to develop to their full potential.

(Cohen 2005, Lake & Ryan 2006)

References


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