2013

CLINICAL SUPERVISION

Calvary Health Care Sydney, Supervision of Students- Intermediate. Pilot program.

In the tradition of the Sisters of the Little Company of Mary with values of Hospitality, Healing, Stewardship & Respect

This Project was possible due to funding made available by Health Workforce Australia

ICTN Project Training

First Focus Hosting

OUR ORGANISATION:

YOUR PRESENTER:

PETER KIESEKER

Master of Health and International Development
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Post Graduate Diploma in Health Promotion
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Bachelor of Human Movement Studies
Diploma of Education
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Peter has worked in health, education, disability, welfare and international aid. Amongst other positions Peter has been a Queensland Regional Superintended of Health, the CEO of a State wide disability service, and the leader of leader of malaria research and eradication programs in Papua New Guinea. He has led also multiple emergency aid teams in Somalia, Sudan, Kenya, Cambodia, Serbia and Kosovo and is published in the Australian Peacekeeping Manual in the topic area of "Non Government agencies working with Military Forces in Emergency Situations". While his daughter was growing up Peter used his generalist education and experience to work as a freelance consultant and trainer. This has included training assignments in Papua New Guinea, Indonesia, Solomon Islands, Fiji, China, Taiwan, Singapore, Nigeria and New Zealand. To support further work in third world aid and development Peter recently became qualified in nursing and is currently bedding down clinical skills in this area.

TABLE OF CONTENTS:

STRATEGIES OF CLINICAL SUPERVISION

INTRODUCTION

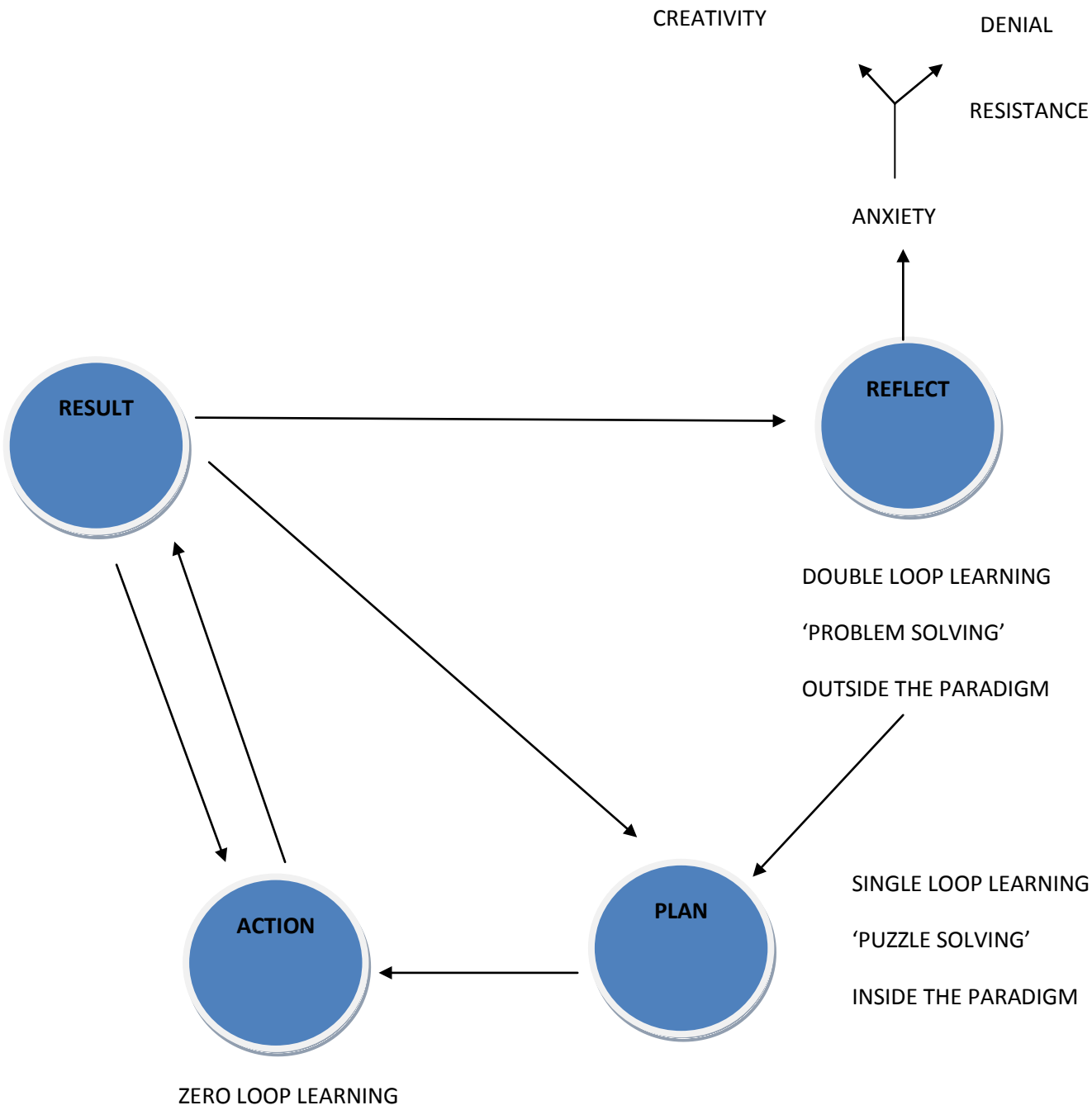
"Mental models are deeply held internal images of how the world works, images that limit us to familiar ways of thinking and acting. Very often, we are not consciously aware of our mental models or the effects they have on our behaviour".

(Peter Senge)

The Workbook and journal is designed to help you gain the most from your experience on the Clinical Supervision Program. It provides you with program material and gives you an opportunity to record your thoughts, feelings, insights and proposed actions as you work through the program. It will help clarify your ideas and enable you to set some achievable goals, based on your learning's.

One of the most important steps in effective learning is reflecting on the experiences you have undertaken. Many clinical supervisors are too busy in their day to day operations to take time out to reflect. Here you have a chance to do just that – reflect and learn.

The first loop is self explanatory – do something, get results – repeating the action achieving the same result. The next stage we add planning to do something different – might lead to a different result. With double loop learning we add reflection which can lead to a whole new answer –transformational and outside the existing paradigm. It may mean a need for free and open inquiry adopting new mental models and knowledge to reframe and look at things in totally new ways.



REFLECTING ON YOUR OWN EXPERIENCES

How do you define Clinical Supervision?

What does clinical supervision offer the supervisee? What does clinical supervision offer clinical practice? What does clinical supervision offer organisation?

What feedback would you have liked to have offered when considering an experience where you were clinically supervised?

What would you describe as good about the supervision you received?

What would you describe as unpleasant, ineffective or perhaps even detrimental about the clinical supervision you received?

CLINICAL SUPERVISION

SOME DEFINITIONS:

Clinical supervision is, "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 clinical situations". (DH, 1993)

Clinical supervision is a process of professional support and learning in which nurses are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues (Fowler 1996).

Launer describes clinical supervision as:

"….an opportunity for a professional to change a story about a working encounter by holding a conversation with another professional…" Launer (2003)

Butterworth and Faugier (1994) suggests clinical supervision is a process that enables us to:

- Identify training and research needs
- Appreciate service user as individuals
- Examine contribution to the multi-disciplinary team
- Identify and develop practice
- Support nurses with their feelings
- Provide a link between research and practice

***Clinical Supervision is a core component of contemporary professional mental health nursing practice and central to practicing within the* ACMHN Standards of Practice for Australian Mental Health Nurses: 2010**

BENEFITS OF CLINICAL SUPERVISION FOR THE SUPERVISEE

- Feel supported
- Experience less stress, burnout and sickness absence
- Develop personally
- Be less inclined to leave their profession
- Notice an increase in their confidence
- Feel less isolated
- Develop their clinical competence and knowledge base

BENEFITS OF CLINICAL SUPERVISION TO CLINICAL PRACTISE

- 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.

BENEFITS OF CLINICAL SUPERVISION TO THE ORGANISATION.

Clinical supervision aims to motivate, while being client-centred and focussed on safeguarding standards of client care. Organisations also benefit from:

- Improved service delivery through the use of evaluation systems
- New learning opportunities
- Improved staff recruitment and retention
- Improved efficiency and effectiveness.

Clinical supervision is also important as a tool to support you with elements of clinical governance in the following ways:

- Quality improvement
- Risk management and performance management
- Systems of accountability and responsibility.

Exercise*: The effective clinical supervision*

Some of the key characteristics for an effective clinical supervisor include:

- An ability to provide a supportive relationship.
- Being able to separate the clinical supervisory role from their work role.
- Being approachable.
- Being open and honest.
- Being non judgemental.
- Having credible knowledge, experience and skills in clinical practice.
- Being a role model by demonstrating a commitment to clinical supervision and the supervisee and themselves being a supervisee.
- An ability to discern clinical needs from personal needs.
- An organisation-wide perspective.
- A formalised method of recording.
- Methods for creating opportunities for improvement and
- Techniques to manage team dynamics.

Other more specific skills that were seen as important, and ones that, as a new clinical Supervisor, you may already have experience in or will need to work towards, are:

- An ability for the provision of educational and emotional support.
- Being a good listener – active listening.
- The ability to facilitate reflection in others through the use of guided questioning.
- Being able to help the supervisee in summarising a clinical supervision meeting.
- Being able to challenge as well as support the supervisee.
- Being able to offer effective feedback.

The clinical supervisor has a responsibility to create a suitable environment for clinical supervision. *Discuss how a clinical supervisor can*:

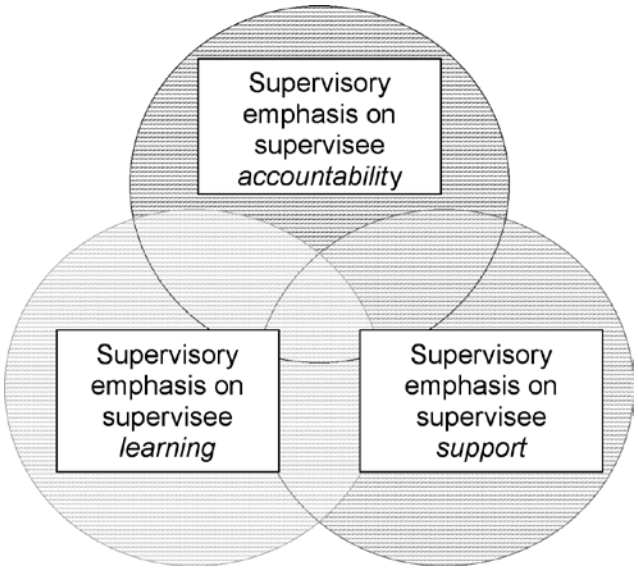
- Creating a safe environment for clinical supervision to happen.
- Removing barriers to effective clinical supervision.
- Ways in which an open and honest clinical supervision relationship can be fostered.
- How equality in the clinical supervision relationship can be promoted.

In relation to you becoming a new clinical supervisor, what in your opinion makes Clinical supervision distinguishable from more managerial forms of supervision in practice?

Some of the differences between clinical and management supervision are likely to be:

Clinical supervision	**Management supervision**
•informal process • enabling process • supports good practice • supervisor within practice • supervisee orientated • record kept by supervisee • fluid aims / objectives • qualitative elements • optional for practitioners • emphasis on support • facilitative authoritative • enhance individual practice	• formal process • monitoring process • insists on good practice • manager often remote from practice • supervisor orientated (manager) • record kept by manager • fixed aims and objectives (e.g. appraisal) • quantitative elements • obligatory for practitioners • emphasis on standards • authoritative • enhance the organisation

Models of Supervision



Clinical supervisor roles based on Proctor's Interactive Model of Supervision (1986)

The Formative Function (Emphasis on Learning) – clinical supervision concerned with the continued development of the skills, abilities and understandings of the Supervisee/practitioner through regular reflection on practice of working in the healthcare environment

- *How to develop an understanding of skills and ability.*
- *How to understand the client better.*
- *How to develop awareness of reaction and reflection on interventions.*
- *How to explore other ways of working.*

The Restorative Function (Emphasis on Support) – Clinical supervision concerned with how the supervisee/practitioner responds emotionally to the stresses and demands of working in the healthcare environment.

- *Exploring the emotional reaction to pain, conflict and other feelings experienced during patient care, can reduce burn out.*

The Normative Function (Emphasis on Accountability) – Clinical supervision concerned with maintaining and monitoring the effectiveness

- *How to address quality control issues*
- *How to ensure nurses' work reaches appropriate standards.*

SIX supervisory styles or interventions available to the clinical supervisor in a Clinical Supervision meeting.

AUTHORITATIVE INTERVENTIONS	FACILITATIVE INTERVENTIONS
Prescriptive: directs behaviour giving advice, making suggestions – 'shoulding'	*Cathartic: space for feelings* encouraging the expression of emotions
Informative: imparting knowledge offering information	*Catalytic: problem solving* drawing issues out and getting below the surface dialogue
Confronting: directly challenging raising awareness of a limiting attitude or behaviour	*Supportive: encouraging* affirming the worth of the individual – non judgemental

You might think that, at first glance, authoritative interventions and facilitative Interventions are helpful in differentiating between managerial forms of supervision and Clinical supervision. However, it is important to stress that all six interventions are open to the clinical supervisor to use and no single one is any better than the others.

All six-category interventions present an observable classification of communication patterns in order to discover any preferred style of the supervisor. In reality, a clinical supervisor is likely to move between the six category interventions depending on their intentions with the supervisee during a clinical supervision meeting.

As a tool in clinical supervisor training, in which the use of role play and being observed by peers is used, the six- category is a useful tool when offering feedback and discussing other options that might have been used with the supervisee.

Some of the key characteristics for an effective clinical supervision relationship include:

- An ability to provide a supportive relationship.
- Being able to separate the clinical supervisory role from their work roles.
- Being approachable.
- Being open and honest.
- Being non judgemental.
- Having credible knowledge, experience and skills in clinical practice.
- Being a role model by demonstrating a commitment to clinical supervision and the supervisee and themselves being a supervisee.

Other more specific skills that were seen as important, and ones that, as a new clinical supervisor, you may already have experience in or will need to work towards, are:

- Being a good listener.
- The ability to facilitate reflection in others through the use of guided questioning.
- Being able to help the supervisee in summarising a clinical supervision meeting.
- Being able to challenge as well as support the supervisee.
- Being able to offer effective feedback.

REPORTED OUTCOMES CATEROGISED TO PROCTOR'S MODEL.

Normative: Professional accountability		
Change of action	Professional identity	Risk taking
Moral sensitivity	Confirming uniqueness of role	Job satisfaction
Problem solving	Change organisation of nursing care	Professional solidarity
Commitment affirmation	Improve individual's nursing care	Confirmation of nursing interventions
Confirmation of actions and role	Critiquing practice	Nurse patient cooperation
Identify solutions	Improving practice	Less patient resistance
Improve nursing practice		Improve patient relationship
Increase understanding of professional issues		
Formative: Skill and knowledge development		
New learning	Competence and creativity	Improved idea time
Improved knowledge	Professional development	Idea support
Professional development (deeper knowledge)	Confirming patient uniqueness	Creativity and innovation
Self confidence	Gaining knowledge	Communication skills
Self-awareness of thoughts and feelings	Competence	
Improved knowledge of human rights	Trust in self	
Recognizing family needs more	Knowledge	
	Insight into therapeutic use of self when relating to patients	
Restorative: Colleague/social support		
Listening and being supportive	Lower perceived anxiety	Improved relationship with nurses
Improved coping at work	Understanding colleagues	Trust
Accessing support	Increased interest	Reduced conflict
Better relationship amongst staff	Relief (discuss thoughts and feelings)	Reduced tedium
Engagement in the workplace	Relief of thoughts and feelings	Reduced burnout
Safe group environment	Empathy	Personal accomplishment
Sense of security	Sense of community	Personal
Satisfaction with nurses	Catharsis	
	Self understanding	

- *What might be the supervisors responsibilities in clinical supervision?*
- *What might be the supervisees responsibilities in clinical supervision?*
- *What might be the shared responsibilities of both?*
- *What might need to be done in the event of a clinical supervision relationship breaking down?*

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.

EXAMPLES OF SOME OF THE SHARED RESPONSIBLITIES IN CLINICAL SUPERVISION ARE:

- Arranging when and where the next meeting will take place.
- Preparing for clinical supervision so time is used effectively.
- Determining the frequency and duration of clinical supervision.
- Maintaining confidentiality for what goes on in a meeting.
- Periodically reviewing the effectiveness of clinical supervision.
- Knowing the boundaries of clinical supervision in relation to the organisational policy.

IN THE EVENT OF A CLINICAL SUPERVISION RELATIONSHIP BREAKING DOWN, IT IS LIKELY THAT:

As a general point, it can be helpful to agree, as part of the supervisory agreement / contract at the initial meeting, where clinical supervisors can get appropriate guidance from if they feel that inappropriate topics are being brought into the meetings by supervisees.

Sources of support for this may include the clinical supervisor's own line manager, another experienced supervisor or the local education provider that supports clinical supervision training. In particular:

- A rationale be given for the reasons for this (often in writing), as this is not always due to dissatisfaction, but perhaps due to a change of circumstance, e.g. leaving the post or needs may be more appropriately met by another supervisor.

- The clinical supervisor may advise the supervisee to access another clinical supervisor from a different discipline/speciality for particular issues/aspects of practice, whilst still remaining the main clinical supervisor.

- Where possible, any disagreements between a supervisee and clinical supervisor will remain between the two parties involved and will be resolved informally. The re-negotiation of the supervisory agreement /contract may assist this process.

- In the event of either party wishing to terminate the supervisory agreement/ contract, it will be acceptable to do so and a record made of this decision and the line manager informed.

STRUCTURING CLINICAL SUPERVISION SESSIONS:

Clinical supervision sessions should be carefully structured and managed with clearly defined aims and objectives.

Create a template for the structure that includes:

- A process
- An evaluation system
- Outcomes to measure success.

Ground rules and responsibilities should be clearly defined, and there should be a contract of commitment that includes:

- Commitment to confidentiality
- Open and honest learning
- Sharing best practice
- Seeking research for evidence-based practice
- Facilitating new learning opportunities
- Relevance to clinical practice

Clinical supervision is an evolving process with experiment and challenge as the building blocks.

Essential Requirements

The Essential Requirements for a Skilled Supervisor are:	The Essential Requirements for a Skilled Supervisee are:
• Managing • Listening • Supporting • Summarising • Challenging • Feedback	• Reflecting • Experimenting • Conceptualising • Planning • Experiencing emotion

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?

NOTES:

SETTING EXPECTATIONS

When establishing a relationship between a supervisee and supervisor, it is important to ensure from the very beginning that clear boundaries are set and both parties have clear expectations of the process.

Staff who are new to a department or clinical area need a comprehensive orientation.

An effective way to set expectations from the very beginning is to discuss:

- Perceived strengths of both parties
- Current concerns or fears
- Areas the supervisee would like to develop
- How the supervisee learns best (recognition of different learning styles)
- What level of support the supervisee currently feels they require
- What the supervisee expects from the supervisory relationship
- What has worked/not worked for the supervisee in supervision in the past.

The supervisor should also discuss with the supervisee:

- The frequency of one-to-one supervision sessions
- Expectations of the supervisee regarding the supervisory relationship
- Availability and willingness to be contacted as assistance is required
- The best way to access advice on a day-to-day basis.

This will assist both parties to manage potential issues or concerns as they arise because a point of reference regarding expectations has been established.

It is important that the supervisor does not perceive or project to others that supervision is a burden.

Supervision is an opportunity to support the development of staff and ensure the delivery of high quality patient care. Supervisors should ensure the staff they are supervising feel genuinely supported and that their role as a supervisor is taken seriously.

Key Points:

- Being a supervisee in practice prior to becoming a clinical supervisor means you are likely to have developed a working knowledge of clinical supervision.
- Giving and receiving feedback on practice is a fundamental purpose of clinical supervision.
- The personal and professional demands of being a clinical supervisor require ongoing organisational support.
- Organisational policies on clinical supervision should reflect shared managerial and practitioner values.
- For new clinical supervisors it can be useful to think of what clinical supervision 'is not' in the absence of a clear definition for practice.
- The clinical supervisor's work expertise may lead to a narrow examination of the supervisee account from practice.
- Effective clinical supervision can be dependent on the personal characteristics of the supervisor, therefore self-awareness skills are just as important as supervisory skills.
- The clinical supervisor has a direct responsibility for creating the environment in which clinical supervision will happen.

Gibbs' model of reflection — practice example

The Reflective Cycle (Gibbs, 1988)

NOTES:

DESCRIPTION:

Describe as a matter of fact what happened during your critical incident or chosen episode for reflection

I was treating a patient with vascular dementia on the ward. I went to get him for therapy but he refused, instead insisting on going to the toilet. I asked him to wait until I got a nurse because he required a minimum of two assist to get out of bed. He then became agitated and attempted to get out of bed. When I asked him to wait until the nurse arrived to help, he became very aggressive. There were no other people in the room. The patient was leaning toward me and talking in a threatening manner, making personal derogatory remarks. He attempted to get out of bed again and fell. I then pressed the buzzer to call assistance. When the nurse arrived, we helped the patient back into bed and called the registrar to check him over. At that time I was asked to leave the room by the registrar and nurse.

FEELINGS:

What were you thinking and feeling at the time?

I was very concerned about the safety of the patient because he fell, about my safety because of the level of aggression displayed towards me as well as my inability to manage the situation. When it was happening I was thinking that I needed to terminate the session as quickly as possible and get help but I felt stuck and I panicked. I was telling myself that I needed to stay in control, but I felt the situation was out of control.

EVALUATION

List the points or tell the story about what was good and what was bad about the experience

I am surprised I was able stay in the room and not burst into tears. I attempted to settle the patient down to the point where I could leave him to get help but I was unsuccessful. Distracting him seemed to work only for a short while. I should have pressed the buzzer earlier. I felt guilty that he fell and embarrassed that I did not think quickly enough on my feet to press the buzzer.

ANALYSIS:

What sense can you make out of the situation? What does it mean?

I think the patient was taken by surprise when I came in. Even though I explained why I was there, he had just woken up and was disoriented. I should have checked with the nurse about his presentation and paid attention to these signs as potential triggers to his aggression. I later found out that the patient was suffering from delirium.

Afterwards I was very upset and tearful. I did not want anyone to know that I was upset so I did not say anything. I felt however that this experience made me doubt my practice and the incident affected my self confidence.

CONCLUSION:

What else could you have done? What should you perhaps not have done?

Because I was in a rush that day I did not have time to plan the session properly or consult with key team members. Despite warnings that this patient can become agitated, I thought I could quickly treat him because I previously had good rapport with him. In hindsight, I think I should have taken the time to organise to see him with a colleague or on another day, but I was overwhelmed with the amount of work I had to get through and patients I had to see.

ACTION PLAN

If it arose again, what would you do differently? How will you adapt your practice in light of this new understanding?

I think that it is not worth "just trying to get though the day". It's important to plan intervention or treatment with patients who are more challenging. I realise now that I contributed toward the incident by not planning my intervention properly and not calling for assistance sooner. I also recognise that it was important for me to talk the incident through with my supervisor and reflect on all aspects of the situation in order to learn from it.

As a supervisor or senior clinician, you may be approached to become a coach or mentor for another staff member. Here are some helpful tips to being a good coach or mentor.

Health Education and Training Institute 2012, *The superguide: a handbook for supervising allied health professionals*, HETI, Sydney Page:6

Do

- Create a safe and supportive environment
- Establish a professional relationship built on mutual respect and trust
- Establish the focus of your coaching/ mentoring relationship, including an agreement for working together
- Collaboratively identify, agree upon and realise the mentoring or coaching goals
- Empathise, show patience and allow the staff member to express feelings
- Provide constructive feedback and clarify how the staff member would like feedback conveyed
- Ask appropriate and relevant questions that facilitate communication and clarification
- Identify and encourage strengths in the staff member
- Encourage the staff member to think reflectively and critically explore options together.

Don't

- Dominate or control the staff member (physically, verbally, psychologically)
- Allow interruptions to your coaching/ mentoring time or be distracted/ interrupted by "more important" issues
- Assume what you think the staff member wants to hear or learn
- Assume that staff members are used to being given constructive feedback
- Take over, show the staff member what to do, show off your knowledge or insist on the staff member doing things your way
- Create dependency on you
- Show irritation, impatience or annoyance
- Talk more than you listen
- Forget what you experienced when you were learning and developing
- Breach confidentiality.

SUPERVISOR CONTRACT EXAMPLE:

Health Education and Training Institute 2012, *The superguide: a handbook for supervising allied health professionals*, HETI, Sydney Page:72

This supervision agreement is made between:

_____ and _____
(Supervisee) (Supervisor)

We agree to the following:

The aim of supervision is to enable the supervisee to reflect in depth on issues affecting practice in order to develop professionally and personally towards achieving, sustaining and developing a high quality and safe service to patients of (organisation) _____.

We will read, discuss and adopt the agreed organisational policy and guidelines on clinical supervision, if appropriate.

The time and place for supervision meetings will be protected by ensuring privacy, time boundaries, punctuality and no interruptions. Sessions will only be cancelled with good cause and an alternative/next date confirmed.

We shall aim to meet regularly as follows:

Frequency: _____ Length of session (approx.):_____

Sessions will be guided by an agenda and agreed to by both supervisor and supervisee but will contain time for ad hoc discussion and reflection where appropriate.

The content of supervision will not be discussed outside the session unless expressly agreed by both parties with the exception of unsafe, unethical or illegal practice being revealed.

Signed: Date:
(Supervisee)

Signed: Date:
(Supervisor)

Source: Adapted from City & Hackney Teaching Primary Care Trust, Clinical Supervision Policy, CL003, July 2006.

CLINICAL SUPERVISION AGREEMENT EXAMPLE:

Health Education and Training Institute 2012, *The superguide: a handbook for supervising allied health professionals*, HETI, Sydney Page:63-74

Date of agreement	
Clinician	
Clinical supervisor	
Team leader	
Review date	

Clinical supervision will address the following areas:

_____
_____
_____

Clinical supervision will take the following form and frequency
(e.g. 1:1 meeting, team meeting, peer shadowing):

_____
_____
_____

Confidentiality:
Our understanding of confidentiality is that the content of support meetings is confidential between the parties, but where there are issues regarding clinical risk and/or performance management, information may need to be shared with other relevant parties.

Should information need to be shared, the supervisor will advise the clinician in advance of this occurring, including what information will be shared, with whom and for what purpose.
Other areas to consider:

_____
_____
_____
_____
_____
_____
_____

Record of clinical supervision
Who will record it?

_____

Where will the records be kept?

_____

Who has access to this information?

_____

What will happen to the clinical supervision notes when: The clinician leaves their position?
Notes will be maintained/Archived in line with record management policies.

Additional information:

_____

Clinical supervision meetings (if applicable)
The clinician will prepare for each meeting by:

_____
_____

The clinical supervisor will prepare for each meeting by:

_____
_____

Should a meeting need to be rescheduled we agree to:

_____
_____

Other considerations

The details of this document can be modified at any time when agreed by both parties.
A copy of this agreement will be given to the team leader/line manager for their records.

Signed:_____ Date:

Name: _____

Signed:_____ Date:

Name: _____

SUPERVISION SESSION OUTLINE EXAMPLE:

Agenda/structure Content

Timing(approx)

Health Education and Training Institute 2012, *The superguide: a handbook for supervising allied health professionals*, HETI, Sydney Page:80

Preparation before session:
Supervisors and supervisees must prepare for a clinical supervision session. The supervisee has to consider what they want to focus on – preparing specific questions prior to the session will help focus thinking and reflection.

- Review notes on what was discussed in previous clinical supervision session.
- Review goals.
- Write notes about what to talk about in clinical supervision.
- Use support materials such as: reflective journal/ portfolio, case notes review, results of measuring outcomes, reflective statements.

Identifying & Exploring 10 mins

- Identify incident or area to focus on and explore/ talk over new issues.
- Reflect on issues affecting practice, caseload planning, decision making.
- Reflect on patient incidents or interventions (eg, assessment skills, counselling skills).
- Review what was discussed at previous clinical supervision session.
- Casework review - Presentation of a clinical issue or patient case by the supervisee.

Analysing 30 mins

- Clarifying, analysing, questioning, challenging actions/ideas and considering options. Discussion and feedback from the supervisor. The supervisor may use questioning to aid the supervisee's reflection and encourage them to reach new conclusions.

Goal setting & Action planning 10 mins
The supervisor may demonstrate a particular treatment for a given situation or draw attention to a particular guideline or outcome measure and may suggest further information gathering through reading.

- Review of issues in conjunction with:
- Relevant theories
- Practice standards
- Quality indicators

Developing ideas about how to incorporate EBP.

Goal setting – problem solving and action plan to achieve goals. SMART goals (specific, measurable, achievable, realistic, timely).

Link the discussion of goals to the last meeting. Assigning new issues to address. Identify short, medium and long-term goals and timeframes to achieve these goals - Tasks are identified to achieve goals.

Summarising 10 mins

Review the session, record and close. It is essential that an outcomes-based action plan is agreed upon at the end of each session. It is recommended that the supervisee records the learning outcomes and action plan from the session.

Reflection in practice

Apply new information/skills/approaches to clinical practice. Ongoing reflection on practice. Bring to next session.

Source: Adapted from Clinical Supervision Program and Procedures, Department of Nutrition & Dietetics, Central Hospital Network, South Eastern Sydney Illawarra Area Health

AS CLINICAL SUPERVISOR, I AGREE TO:

- Meet punctually at regular intervals to offer a minimum of 1hour and 30minutes of supervision per week.
- Meet in an environment in which there is as little interruption as possible.
- Maintain confidentiality, which means no information brought up by _____ will be discussed outside the supervisory session apart from:
    - Within my own supervision (of supervision) where only Christian names will be revealed.
    - When there has been a breach of BABCP code of ethics/practice and following discussion with the supervisee it may be necessary to divulge information to other parties (manager, BABCP).
- Treat _____ in a professional manner.
- Keep records of supervision sessions in a secure place — locked filing cabinet in my office.
- Make myself available by telephone between sessions for consultation for urgent matters.
- Adhere to the applicable professional standards and codes of ethics.
- Prepare for supervision sessions.
- Support, encourage and give constructive feedback.
- Challenge practice which is unethical, unwise, insensitive or incompetent.
- Challenge blindspots.
- Review the usefulness of the work done after 6months and if necessary re- negotiate the contract.
- Negotiate with _____ when and if necessary to make changes to the Contract.
- Support _____ in his/her pursuit for BABCP accreditation.

CLINICAL SUPERVISION CONTRACT:

As the Clinical Supervisor and Supervisees we have discussed and have agreed the following:-

- To work together to facilitate an in depth reflection on issues relating to practice.
- To meet on a monthly basis for 1hr for individuals and up to 2 hours depending the number in the group.
- To protect and value the time and space for Clinical Supervision by keeping the agreed appointment.
- To respect each other's views and be open to feedback.
- The date and time for the next session will be arranged at the end of each session.
- Note Taking – we all take responsibility for our own note taking, it is paramount that this information is kept confidential and patients are not identifiable. The only exceptions will be if issues are discussed which compromise any Professional Code of Conduct/Child protection or Vulnerable adult issues.
- We will review the clinical supervision session after the 4th session.
- The sessions will be confidential but not secret; (if anything is disclosed that is breaking professional codes of conduct, trust policy or is illegal I have a duty of care to alert the relevant manager/director. Should this arise I will inform you and give you the option of halting the session in order to contact your Manager and Trade Union representative. I will notify the manager after 24 hours and any information relating to the matter may be included in a statement at a later date.)

Statement of what is required: As the Clinical Supervisee I agree to the following

- To be prepared for each session (individual or group issue).
- Taking responsibility for making the best use of time in being punctual for sessions and for any outcomes of the session.
- Be open to learning and to accept challenges and support.
- To take the responsibility for arranging a room where we can meet in privacy and interruptions can be avoided.

As the Clinical Supervisor I agree to the following

- To offer support
- To challenge respectfully
- To inform your manager if you repeatedly fail to attend clinical supervision
- To use my own Clinical Supervisor to support and develop my own abilities as a Clinical Supervisor without breaking confidentiality.

Signatures

Supervisor: Supervisee:

Date:

Considering individual differences when facilitating learning

Understanding difference is important for facilitators wanting to gain insight into how different learners approach tasks, what motivates them and how to minimise generational bias when facilitating a learning activity.

Adults' learning styles often reflect their previous learning experiences, their cultural background and generation.

Possible characteristics of different learners across the generations

Baby Boomers Baby Boomers (born 1943-1960) Left school 1960-1978	Generation X (born 1961-1980) Left school 1979-1998	Generation Y (born 1981-2000) Left school 1999-2018
Strong work ethic; come prepared to the learning opportunity.	Want to learn usable skills.	Value knowledge access over knowledge memorisation. Experts in searching and accessing information, but not necessarily in analysing or synthesising the information.
May prefer more traditional methods of learning rather than a self-taught module.	Want things presented in a straightforward manner.	Want to take on challenging tasks in their learning environment (thus may appear arrogant if the instruction is vague.
May be less comfortable with technology but are conscientious and accept help.	Enjoy flexibility in their learning (e.g. self-directed modules).	Are computer savvy and use technology whenever possible.
Learn best when experience can be integrated with subject matter.	Want learning to be directly relevant to their work tasks. Don't want to learn something just for the sake of learning.	Expect immediate feedback on their work as they are accustomed to information access 24/7.
Anticipate a slower paced and more formal introduction of the training and rationale for it – like to have a hard copy.	Want to learn in the easiest and quickest way possible.	Need to feel a sense of achievement. Want goals and rules to be transparent. Prefer experiential activities.

Not everyone learns the same way as I do. We are all individuals and diversity is a strength.

Calvary Health Care Sydney, Supervision of Students- Intermediate. Pilot program. In the tradition of the sisters of the Little Company of Mary with values of Hospitality, Healing, Stewardship & Respect. *This project was possible due to funding made available by Health Workforce Australia.*

REFLECTION:

Role Play

The following situations could occur in a clinical supervision session. How would you address these?

1. Your Supervisee has been promoted to a supervisory role. She finds it hard to cope with the new responsibilities and has suffered a loss of confidence as a result. She wants to hand in her notice.

2. It has been noted that your supervisee seems to lack tolerance with certain types of patients; seemingly those who complain a great deal.

3. A patient's safety was put at risk due to what you think was a student supervisee's lack of knowledge or skill (e.g. correct application of a ROM frame, leaving a partially sighted rehabilitation patient unattended in front of a hot plate, misjudgement of the level of thickened fluid a patient can tolerate).

4. Your supervisee needs to be able to understand and apply an uncommon procedure and is seeking your assistance.

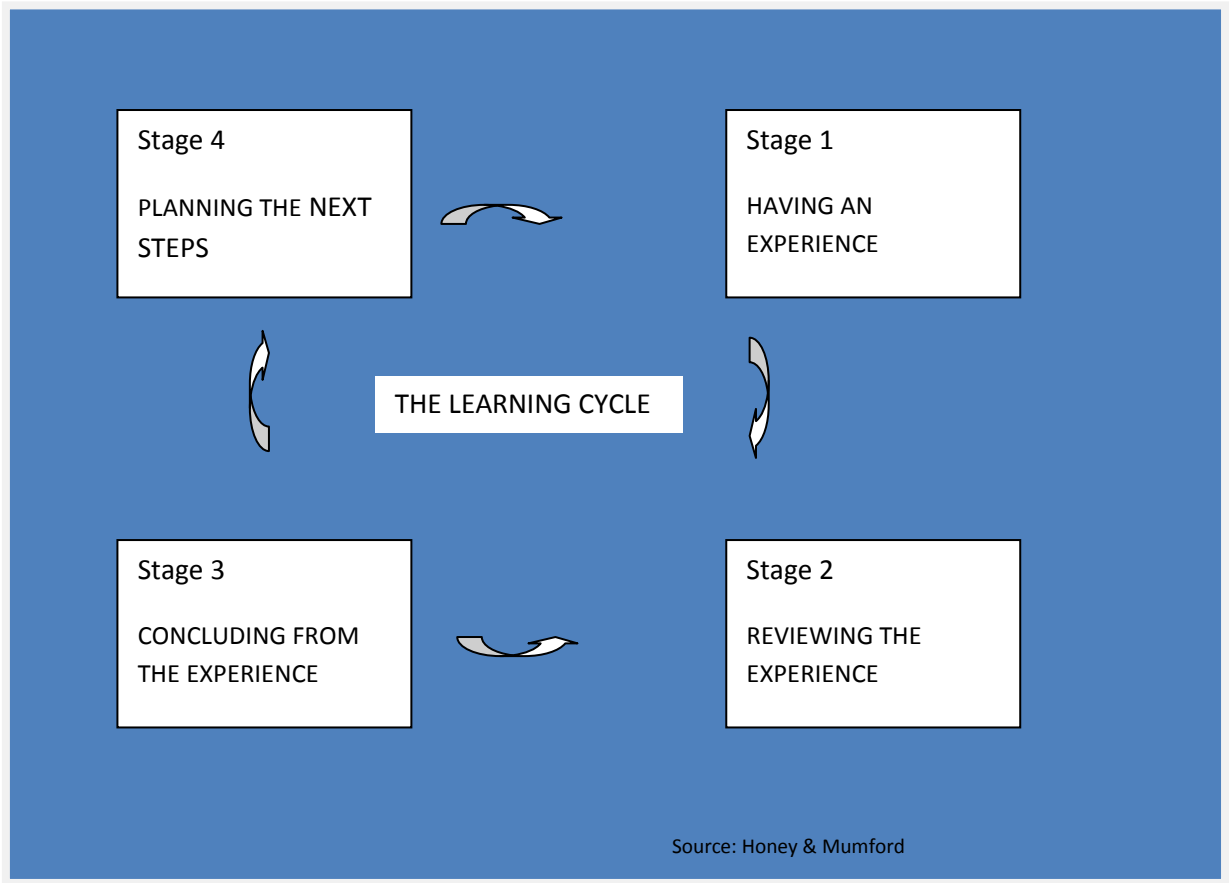
5. Your once very efficient Supervisee seems to have lost interest in the job. His/her work rate has fallen and other staff members have started to comment on this.

6. Your Supervisee, who is rarely away ill has suddenly been repeatedly absent from work; He/she gives what seems to be poor excuses and is evasive on the issue. You do not feel that it is a discipline problem.

7. Your Supervisee has come to you to complain of bullying on the ward. You have noticed that her work and timekeeping has become erratic and she seems despondent.

LEARNING STYLES

LEARNING STYLES



Intentional Learning is a process that can be broken down into meaningful parts.

STAGE 1

Fortunately you have many experiences in your daily life, whether you chose to view them as a learning experience is up to you.

STAGE 2

To learn from an experience it is necessary to review what occurred. This requires you to critically reflect upon the situation you were involved in or just observed.

STAGE 3

Once you have reviewed your experience, conclusions can then be drawn to explain what you experienced. A number of possible conclusions might be reached at this point.

STAGE 4

Armed with your conclusions you need to decide what to do with this information and what steps to take next. This involves deciding what you will do differently next time in light of the conclusions drawn.

LSI QUESTIONAIRE

Participant Name:

This questionnaire is designed to find out your preferred learning style(s). Over the years you have probably developed learning "habits" that help you benefit more from some experiences than from others.

Since you are probably unaware of this, this questionnaire will help you pinpoint your learning preferences so that you are in a better position to select learning experiences that suit your style.

There is no time limit on this questionnaire. It will probably take you 10-15 minutes. The accuracy of the results depends on how honest you can be.

If you **agree** more than you disagree with a statement put a **tick** by it.

If you **disagree** more than you agree put a **cross** by it.

Be sure to **mark each item with either a tick or cross**.

1. I have strong beliefs about what is right and wrong, good and bad.

2. I often act without considering the possible consequences.

3. I tend to solve problems using a step-by-step approach

4. I believe that formal procedures and policies restrict people.

5. I have a reputation for saying what I think, simply and directly.

6. I often find that actions based on feelings are as sound as those based on careful thought and analysis.

7. I like the sort of work where I have time for thorough preparation and implementation.

8. I regularly question people about their basic assumptions.

9. What matters most is whether something works in practice.

10. I actively seek out new experiences.

11. When I hear about a new idea or approach I immediately start working out how to apply it in practice.

12. I am keen on self discipline such as watching my diet, taking regular exercise, sticking to a fixed routine, etc

13. I take pride in doing a thorough job.

14. I get on best with logical, analytical people and less well with spontaneous, 'irrational' people

15. I take care over the interpretation of data available to me and avoid jumping to conclusions.

16. I like to reach a decision carefully after weighing up many alternatives.

17. I'm attracted more to novel, unusual ideas than to practical ones.

18. I don't like disorganised things and prefer to fit things into a coherent pattern.

19. I accept and stick to laid down procedures and policies so long as I regard them as an efficient way of getting the job done.

20. I like to relate my actions to a general principle.

21. In discussions I like to get straight to the point.

22. I tend to have distant, rather formal relationships with people at work.

23. I thrive on the challenge of tackling something new and different.

24. I enjoy fun-loving, spontaneous people.

25. I pay meticulous attention to detail before coming to a conclusion.

26. I find it difficult to produce ideas on impulse.

27. I believe in coming to the point immediately.

28. I am careful not to jump to conclusions too quickly.

29. I prefer to have as many sources of information as possible – the more data to think over the better.

30. Flippant people who don't take things seriously enough usually irritate me.

31. I listen to other people's points of view before putting my own forward.

32. I tend to be open about how I'm feeling.

33. In discussions I enjoy watching the manoeuvrings of the other participants.

34. I prefer to respond to events on a spontaneous, flexible basis rather than plan things out in advance.

35. I tend to be attracted to techniques such as network analysis, flow charts, branching programs, contingency planning, etc.

36. It worries me if I have to rush out a piece of work to meet a tight deadline.

37. I tend to judge people's ideas on their practical merits.

38. Quiet, thoughtful people tend to make me feel uneasy.

39. I often get irritated by people who want to rush things.

40. It is more important to enjoy the present moment than to think about the past or future.

41. I think that decisions based on a thorough analysis of all the information are sounder than those based on intuition.

42. I tend to be a perfectionist.

43. In discussions I usually produce lots of spontaneous ideas.

44. In meetings I put forward practical realistic ideas.

45. More often than not, rules are there to be broken.

46. I prefer to stand back from a situation and consider all the perspectives.

47. I can often see inconsistencies and weaknesses in other people's arguments.

48. On balance I talk more than I listen.

49. I can often see better, more practical ways to get things done.

50. I think written reports should be short and to the point.

51. I believe that rational, logical thinking should win the day.

52. I tend to discuss specific things with people rather than engaging in social discussion.

53. I like people who approach things realistically rather than theoretically.

54. In discussions I get impatient with irrelevancies and digressions.

55. If I have a report to write I tend to produce lots of drafts before settling on the final version.

56. I am keen to try things out to see if they work in practice.

57. I am keen to reach answers via a logical approach.

58. I enjoy being the one that talks a lot.

59. In discussions I often find I am the realist, keeping people to the point and avoiding wild speculations.

60. I like to ponder many alternatives before making up my mind.

61. In discussions with people I often find I am the most dispassionate and objective.

62. In discussions I'm more likely to adopt a 'low profile' than to take the lead and do most of the talking.

63. I like to be able to relate current actions to a longer term bigger picture.

64. When things go wrong I am happy to shrug it off and 'put it down to experience'.

65. I tend to reject wild, spontaneous ideas as being impractical.

66. It's best to think carefully before taking action.

67. On balance I do the listening rather than the talking.

68. I tend to be tough on people who find it difficult to adopt a logical approach.

69. Most times I believe the end justifies the means.

70. I don't mind hurting people's feelings so long as the job gets done.

71. I find the formality of having specific objectives and plans stifling.

72. I'm usually one of the people who puts life into a party.

73. I do whatever is expedient to get the job done.

74. I quickly get bored with methodical, detailed work.

75. I am keen on exploring the basic assumptions, principles and theories underpinning things and events.

76. I'm always interested to find out what people think.

77. I like meetings to be run on methodical lines, sticking to laid down agenda, etc.

78. I steer clear of subjective or ambiguous topics.

79. I enjoy the drama and excitement of a crisis situation.

80. People often find me insensitive to their feelings.

LSI SCORING

To determine your preferred learning style, score one point for each item you ticked. There are no points for items you crossed.

CIRCLE THE NUMBERS BELOW THAT YOU TICKED AND THEN TOTAL

ACTIVIST	REFLECTOR	THEORIST	PRAGMATIST
2	7	1	5
4	13	3	9
6	15	8	11
10	16	12	19
17	25	14	21
23	28	18	27
24	29	20	35
32	31	22	37
34	33	26	44
38	36	30	49
40	39	42	50
43	41	47	53
45	46	51	54
48	52	57	56
58	55	61	59
64	60	63	65
71	62	68	69
72	66	75	70
74	67	77	73
79	76	78	80
Total:	**Total:**	**Total:**	**Total:**
Activist:	**Reflector:**	**Theorist:**	**Pragmatist:**

CIRCLE YOUR SCORES ON THIS CHART AND JOIN THEM UP

ACTIVIST	REFLECTOR	THEORIST	PRAGMATIST	*PREFERENCE*
20 19 18 17 16 15 14 13	20 19 18 	20 19 18 17 16	20 19 18 17 	Very strong preference
12 11	17 16 15	15 14	16 15	Strong preference
10 9 8 7	14 13 12	13 12 11	14 13 12	Moderate Preference
6 5 4	11 10 9	10 9 8	11 10 9	Low Preference
3 2 1 0	8 7 6 5 4 3 2 1 0	7 6 5 4 3 2 1 0	8 7 6 5 4 3 2 1 0	Very Low Preference

LSI GENERAL DESCRIPTIONS

ACTIVIST PREFERENCE

Activists involve themselves fully and without bias in new experiences. They enjoy the here and now and are happy to be dominated by immediate experiences. They are open-minded, not sceptical, and this tends to make them enthusiastic about anything new. Their philosophy is: “I'll try anything once”. They tend to act first and consider the consequences afterwards. Their days are filled with activity. They tackle problems by brainstorming. As soon as the excitement from one activity has died down they are busy looking for the next. They tend to thrive on the challenge of new experiences but are bored with implementation and longer-term consolidation. They are gregarious people constantly involving themselves with others but in doing so, they seek to centre all activities around themselves.

REFLECTOR PREFERENCE

Reflectors like to stand back to ponder experiences and observe them from many different perspectives. They collect data, both first hand and from others, and prefer to think about it thoroughly before coming to any conclusion. The thorough collection and analysis of data about experiences and events is what counts so they tend to postpone reaching definitive conclusions for as long as possible. Their philosophy is to be cautious. They are thoughtful people who like to consider all possible angles and implications before making a move. They prefer to take a back seat in meetings and discussions. They enjoy observing other people in action. They listen to others and get the drift of the discussion before making their own points. They tend to adopt a low profile and have a slightly distant, tolerant, unruffled air about them. When they act it is part of a wide picture which includes the past as well as the present and others' observations as well as their own.

THEORIST PREFERENCE

Theorists adapt and integrate observations into complex but logically sound theories. They think problems through in a vertical, step-by-step logical way. They assimilate disparate facts into coherent theories. They tend to be perfectionists who won't rest easy until things are tidy and fit into a rational scheme. They like to analyse and synthesise. They are keen on basic assumptions, principles, theories models and systems thinking. Their philosophy prizes rationality and logic. “If it's logical it's good”. Questions they frequently ask are: “Does it make sense?” “How does this fit with that?” “What are the basic assumptions?” They tend to be detached, analytical and dedicated to rational objectivity rather than anything subjective or ambiguous. Their approach to problems is consistently logical. This is their “mental set” and they rigidly reject anything that doesn't fit with it. They prefer to maximise certainty and feel uncomfortable with subjective judgments, lateral thinking and anything flippant.

PRAGMATIST PREFERENCE

Pragmatists are keen on trying out ideas, theories and techniques to see if they work in practice. They positively search out new ideas and take the first opportunity to experiment with applications. They are the sort of people who return from management courses brimming with new ideas that they want to try out in practice. They like to get on with things and act quickly and confidently on ideas that attract them. They tend to be impatient with ruminating and open-ended discussions. They are essentially practical, down to earth people who like making practical decisions and solving problems. They respond to problems and opportunities “as a challenge”. Their philosophy is: “There is always a better way” and “If it works it's good”.

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THE CONTRIBUTIONS OF DIFFERENT LEARNING STYLES OF CLINICAL SUPERVISORS:

Where a supervisor has a choice it is quite likely that whatever their style, they could be encouraged to take an organised rational view. However, most learning depends on relatively immediate reactions to on the job situations. Here, the preferences of the manager will take a more natural and therefore in some cases less structured and analytical form.

For example, Activist supervisors will provide experiences as an immediate response to situations and will happily throw team members in “at the deep end”. Such supervisors will not provide systematic, analytic experiences. Equally, strong Reflector supervisors will want to organise the learning experience in advance and expect a serious review after the event. They will be less likely to encourage team members to take chances and risks.

Our views about the ways in which different styles would influence what a supervisor may offer are on the following pages.

A. THE ACTIVIST SUPERVISOR

Activists tend to help by:

- Generating (unconsciously) opportunities for others to observe and reflect on what they do.
- Taking an optimistic and positive view of what is involved in a new situation.
- Giving a positive and encouraging lead, at least initially, in short term active learning activities.
- Following through with action to provide learning experiences if they have been convinced of their value.
- Responding spontaneously to opportunities as they arise.

Activists will be less likely to provide help through:

- Providing planned learning experiences.
- Giving support to learning as a planned, structured activity.
- Assessing and using learning experiences which are different from those through which they learned.
- Discussing learning opportunities beforehand and reviewing them afterwards.
- Standing back and allowing others to participate or take action.
- Giving a good personal model of planned learner behaviour.
- Giving different learning experiences to team members with different learning styles.

B. THE REFLECTOR SUPERVISOR

Reflectors will tend to help by:

- Suggesting activities, which can be observed
- Recommending how observation can be carried out.
- Identifying ways in which an event or a problem can be analysed .Discussing what may happen, and reviewing what has happened.
- Providing data or feedback in a controlled learning situation.
- Advising on how to prepare carefully for a management activity.
- Not taking a dominant role in meetings with team members.
- Emphasising the importance of collecting data before acting.
- Giving a considered response to requests for help.

Reflectors will be less likely to provide help through:

- Suggesting ad hoc immediate learning opportunities.
- Showing how to take advantage spontaneously of unplanned learning activities.
- Providing unexpected or slightly risky learning situations (sudden delegation of a task).
- Giving immediate answers to unexpected requests for direct help.
- Providing a large-scale view of philosophy, concept, system or policy.
- Providing a strong personal model of anything except Reflector behaviour.

C. THE THEORIST SUPERVISOR

Theorists will tend to help by:

- Showing interest in any intellectually respectable idea.
- Helping people to describe underlying causes, to explain the systems or concepts involved in an activity.
- Demonstrating the intellectual validity of an answer or process.
- Showing how to strengthen or demolish a case by the use of logic.
- Bringing out complexities.
- Aiming for clarity of structure of purpose.
- Articulating theories, eg Open Systems Theory or Total Quality Management.
- Generalising reasons why something works or does not work.
- Setting high standards in the quality of data.

Theorists will be less likely to provide help through:

- Showing when to accept the obvious.
- Helping others to understand emotions and feelings in specific circumstances.
- Making use of data or occasions that conflict with their theories.
- Developing others who are different in intellectual capacity or style, e.g. if perceived as lower calibre, or if theories clash with their own.
- Showing how to use information, which they regard as trivial, irrelevant or intellectually not respectable and drawing up specific action plans.

D. THE PRAGMATIST SUPERVISOR

Pragmatists will tend to help by:

- Showing responsiveness to new ideas and techniques.
- Demonstrating interest in specific action plans.
- Pressing for relevant learning programmes with clear pay off.
- Being open to new situations.
- Showing a belief in the possibility of improvement.
- Following the party line on, e.g. appraisals or releasing people for courses.
- Following specific suggestions on how to improve learning.

Pragmatists will be less likely to provide help through:

- Being responsive to ideas or techniques not immediately relevant to a current problem.
- Showing interest in concepts or theories.
- Encouraging action relevant to the longer term.
- Encouraging ideas or learning programmes that they regard as unproven or way out.
- Pushing for action that is apparently not valued by the culture or system.

LEARNING STYLES

Reflecting on Learning Styles

We all learn in different ways. Some of us prefer to study in depth and learn as we go along.

Some of us are satisfied when the methods we use get the job done; others are more concerned with why a particular approach proved successful. Yet others spend time thinking through how the task could be tackled more effectively next time.

Research by Peter Honey and Alan Mumford identified four basic "learning styles".

It is helpful to understand our own learning style preference and also that of others. When working with others we can be mindful of the important part that learning styles play so that we can take differences into account to be more effective.

1.What is my preferred learning style?

2. How might this affect the way I supervise someone?

3. What strengths does my style provide for me?

4. Knowing my learning style, what can I do differently to be more effective when working with others?

"Insanity: doing the same thing over and over again and expecting different results." Albert Einstein

REFLECTION:

BARRIERS TO LEARNING

BARRIERS TO LEARNING

Educators should recognise that difference exist amongst learners and adopt appropriate strategies to maximise learning. Educators are required to consider the following:

- Not every learner has the same purpose or the same motivation for learning in a particular situation.
- Not every learner is at the same stage of understanding or skill, and at the same stage of readiness for the next step.
- Learners vary in the way they perceive information and learn
- Learners will vary as to the amount of assistance required and when that assistance is required.
- Learners will require varying amounts of practice to master new learning.

Identifying various barriers to learning will assist with the choice of training methods used.

Some common barriers to learning are listed below:

Possible Barrier	**Example**
Language, literacy	Language difficulties, non-English speaking background
Cultural background	Socio-economic, religious beliefs, cultural differences, level of support
Physical impairment	Poor sight, poor hearing, impaired dexterity, strength level
Previous experience/learning	Level of education, type and degree of previous experience
Learning styles	Preferred theory to practise or vice versa, likes constant revision/practise, prefers self pacing material to presentations
Motivation	Not highly motivated, not interested, history of failure
Personality traits	Poor self image, loner, insecure about abilities

*How might these be barriers to learning**?***

FEEDBACK PRINCIPLES AND PRACTISES:

Suggestion for Giving Feedback

- Cover one thing at a time
- Be balanced – focus on behaviours to keep as well as things to change
- Focus on behaviours (not the person)
- Be specific - give examples of what you experienced
- Describe the impact of their actions/behaviour
- Provide alternatives – share ideas
- Ask for their view – listen
- Limit the amount of feedback
- End on a positive – reiterating positive feedback or providing a positive way forward

Rules for giving Negative Feedback

- Don't avoid it
- Avoid historical references – here and now vs. there and then
- Never in public
- Balance – behaviors to keep as well as change
- Avoid undue emotion
- Avoid insincere praise – undermines trust
- Do not reject person (You never get it right) – maintain self-esteem
- Avoid communication overload
- Avoid amateur psychoanalysis
- Avoid premature judgements
- Avoid buck passing – assume full responsibility for your area of accountability
- Avoid threats – if behavior merits discipline take action promptly
- Give a path forward, provide alternatives – end positively

Suggestions for Receiving Feedback

- Listen first
- Listen actively
- Ask questions — your session is a dialogue
- Evaluate it - Understanding does not equal agreement
- Do not defend or justify
- You own it
- Thank your feedback giver
- Avoid explaining/justifying why you did something
- Don't interrupt
- Ask questions for understanding
- Compare to previous feedback
- Make notes
- Consider ways forward
- Seek it

Role "CLAB"

- Clarity – do people know what is expected of them, to what standard?
- Legitimacy – do they have sufficient responsibility, power and authority?
- Adequacy – do they have the knowledge and skills?
- Boundaries – do they know where their role stops and starts?

FEEDBACK MODELS:

Liked/disliked Formula

I liked –

The clear way you explained the rationale"

I disliked –

"The way you interrupted when I was speaking"

What I'd like you to do in future is –

"Wait for me to finish before you speak'

SEE – Situation, Evidence, Effect

SITUATION: (Location and Time)

- Describe – place and time the behavior occurred. e.g. "At the meeting yesterday ..."

EVIDENCE: (Observable Action)

- What you saw and heard (as in a recorded video). e.g. "... you were very clear and provided a good example for the team ..."

EFFECT: (Consequence, Result/Outcome)

- Describes the effect of the behavior – e.g. on work outcomes, quality, client satisfaction, the team. e.g. " ... so they were able to learn how you dealt with that issue"

Balanced Feedback Formula

- What I appreciated/liked about what you did was…….
- What I was concerned about was…….
- What you might do instead is……

DESC

- D - Describe
- E - Explain
- S - Specify
- C - Consequences + & -

2 & 2

- I liked these 2 things xxxxx
- Because xxxxx
- And
- With extra attention we will be able to improve these 2 things xxxxx

1.Describe current behaviors: Describe current behaviors that you want to reinforce (praise) or redirect (criticism) to improve a situation	**2. Identify situations:** Identify the specific situation(s) where you observed these behaviors**.**
3. Describe impacts and consequences: Describe the impacts and consequences of the current behaviors.	**4. Identify alternative behaviors**
5.	**6.**

ACTIVITY BRIEF:

Exercise in pairs

1. Do some individual preparation

2. Use the pre-work i.e. " a piece of feedback you need to give someone"

3. Give one another a brief background

4. Give the feedback

5. Ask how it felt on the receiving end

6. Swap and repeat

Total time approx. 5 minutes

SUMMARY: FEEDBACK CHARACTERISTICS

It must be timely

- The closer to the behavior the more reinforcement, enhancement or redirection is likely.

It must be specific

- Address specific behaviors and actual performance, not the perceived qualities of the other person.

It must fit the individual

- It must fit the perceptions of the coachee, not the coach.

It must be relevant to goals

- For the individual, team and organisation
- Based upon some agreed-upon standard
- Clearly defined and quantifiable.

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SITUATIONAL LEADERSHIP

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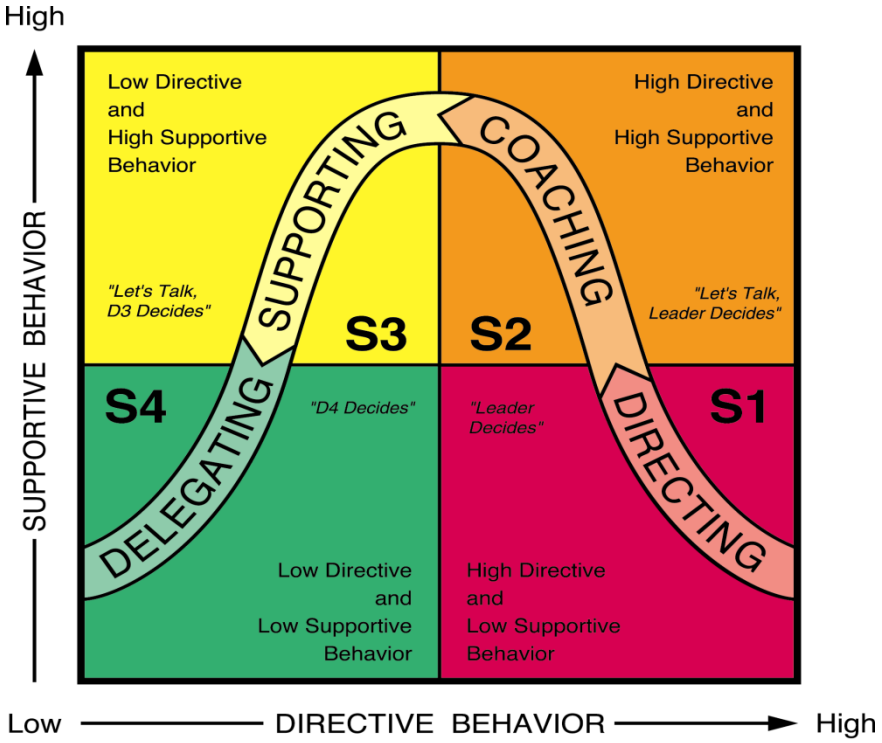
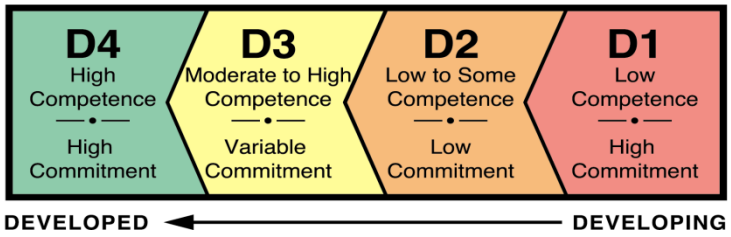
SITUATIONAL SUPERVISION





Kenneth Blanchard, 1994,*Leadership and The One Minute Manager*

DEVELOPMENT LEVEL 1

D1 Needs

- Recognition of enthusiasm and transferable skills
- Clear goals
- Standards for what a good job looks like
- Information on how data about performance will be collected and shared
- Hands on training
- Action plans—direction about how, when and with whom
- Timelines
- Priorities
- Boundaries, limits on authority and responsibility
- Frequent feedback on results

CLINICAL SUPERVISION: STYLE 1

S1 Behaviours

- Acknowledge the team members enthusiasm
- Acknowledge the team member's transferable skills and progress to date
- Identified desired outcomes, goals and timelines
- Define what a good job looks like and how performance will be tracked and monitored
- Develop a plan for the team member to learn new skills
- Take the lead in action planning
- Make most of the decisions about what, when and with whom
- Provide specific direction and instruction
- Take the lead in problem solving
- Provide frequent follow-up and feedback

DEVELOPMENT LEVEL 2: LOW TO SOME COMPETENCE, LOW COMMITTMENT.

Competence and Commitment D2:

What are the indicators of low competence?

What are the indicators of high commitment?

Needs of D2:

DEVELOPMENT LEVEL 2:

D2 Needs:

- Clear goals
- Perspective
- Frequent feedback on results
- Praise for making progress
- Assurance that it is ok to make mistakes
- Explanations of why
- Opportunities to discuss concerns
- Involvement in decision making and problem solving
- Encouragement

CLINICAL SUPERVISION: STYLE 2

S2 Behaviours

- Involve team member in identifying problems and in setting goals
- Provide support, reassurance and praise
- List, offer the tem members an opportunity to discuss concerns and share ideas
- Involve the team member in problem solving and decision making
- Make final decisions about action plans after listening to the team member's ideas and feelings
- Provide direction and coaching to continue building and refining skills
- Explain why a particular approach is being taken
- Provide perspective about how long things should take and feedback about whether development and performance is on track
- Define what a good job will look like and how performance will be tracked *with* the team member
- Continue to provide frequent follow-up and feedback

DEVELOPMENT LEVEL 3 – HIGH COMPETENCE, VARIABLE COMMITMENT

Competence and Commitment D3

What are the indicators of high competence?

What are the indicators of variable commitment?

Needs of D3:

DEVELOPMENT LEVEL 3

D3 Needs

- An approachable mentor or coach
- A sounding board
- Opportunities to express concern and be heard
- Support and encouragement to develop problem-solving skills
- Help in looking at ails objectively, so confidence is built
- To have ideas listened to and implemented
- An opportunity to affirm commitment to the goal
- Praise and recognition for high levels of competence and performance
- Obstacles to goal accomplishment removed
- Opportunities to work with others and be part of a team working on the same goals

CLINICAL SUPERVISION: STYLE 3

S3 Behaviours

- Share responsibility for problem identification and goal setting with the team member
- Ask the team member to take the lead in action planning and problem solving
- Serve as a sounding board, encouraging the team member to discuss concerns and ideas
- Listen and encourage self-reliant problem solving and decision making
- Provide reassurance, support, encouragement and praise
- Explain ways to make the goal or task more interesting and challenging, if motivation is low
- Provide help in problem solving ys sharing ideas, if asked
- Work with team members to evaluate his or her work

DEVELOPEMNT LEVEL 4 – HIGH COMPETENCE, HIGH COMMITTMENT

Competence and Commitment D4

What are the indicators of high competence?

What are the indicators of high commitment?

Needs of D4:

DEVELOPMENT LEVEL 4

D4 Needs

- Variety and challenge
- A leader who is more of a mentor and colleague than a boss
- Acknowledgement of contributions
- Autonomy and authority
- Trust

CLINICAL SUPERVISION: STYLE 4

S4 Behaviours

- Enable the team member to take charge
- Define the problems and desired outcomes with the team member
- Expect the team member to take the lead in goal setting, action planning and decision making
- Encourage the team member to evaluate his or her own work
- Provide opportunities for the team member to share in and celebrate successes and mentor others
- Recognise, value and reward the team members contributions to the organisation
- Challenge the team member to even higher levels of performance.

SITUATIONAL SUPERVISION

Job Task or Responsibility (*a different chart is completed for **EACH** job or task)*

Task:

Task Experience	Has experience relevant to task 8 7 6 5 4 3 2 1 Does not have relevant experience
Task Knowledge	Possesses necessary task knowledge 8 7 6 5 4 3 2 1 Does not have necessary task knowledge
Solving Task Problems	Can solve problems independently 8 7 6 5 4 3 2 1 Unable to solve problems independently
Ability to Take Responsibility	Can be left alone 8 7 6 5 4 3 2 1 Unable to solve problems independently
Meeting Task Deadlines	Always meets deadlines 8 7 6 5 4 3 2 1 Never finishes task on time
A Competence Sub-totals	
Willingness to take Responsibility	Is very enthusiastic 8 7 6 5 4 3 2 1 Is very reluctant
Achievement Motivation	Has a hire desire to succeed 8 7 6 5 4 3 2 1 Has little desire to achieve
Persistence	Won't quit until done 8 7 6 5 4 3 2 1 Gives up easily
Attitude to the Task	Enjoys the task 8 7 6 5 4 3 2 1 Dislikes the task intensely
Independence	Always meed deadlines 8 7 6 5 4 3 2 1 Never finishes task on time
B Commitment Sub-totals	
Development Level	
Appropriate Leadership Style	

Data Matrix

A 33-40 B 5-12 D3-S3	A 23-32 B 5-12 D2/3-S2/3	A 13-22 B 5-12 D2-S2	A 5-12 B 5-12 D2-S2
A 33-40 B 13-22 D3-S3	A 23-32 B 13-22 D2/3-S2/3	A 13-22 B 13-22 D1/2-S1/2	A 5-12 B 13-22 D2-S2
A 33-40 B 23-32 D3/4 – S3/4	A 23-32 B 23-32 D3-S3	A 13-22 B 23-32 D1/2-S1/2	A 5-12 B 23-32 D1-S1
A 33-40 B 33-40 D4/S4	A 23-32 B 33-40 D3/4-S3/4	A 13-22 B 33-40 D1-S1	A 5-12 B 33-40 D1-S1

REFLECTION:

COACHING MODELS TO AID LEARNING

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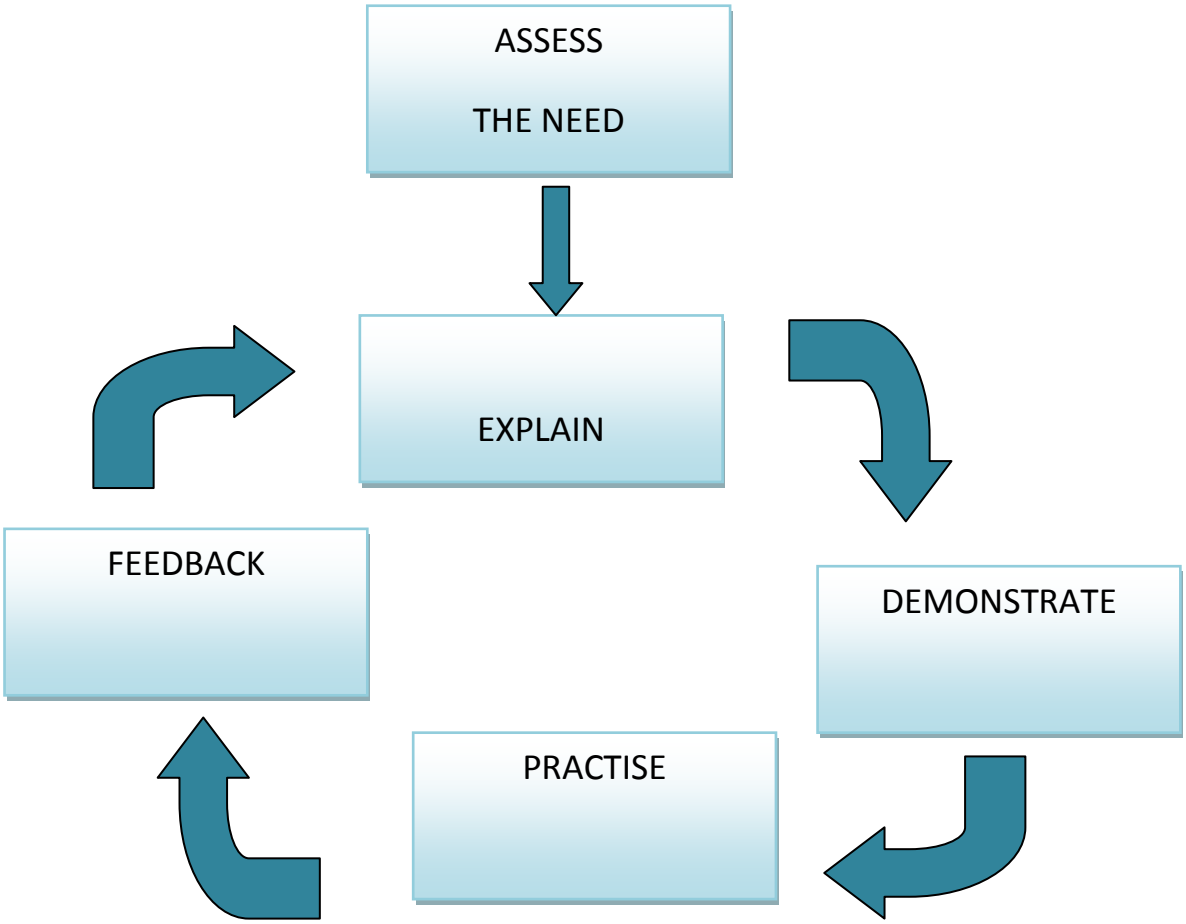
COACHING MODELS TO AID LEARNING

The Model – Skills Based Coaching:

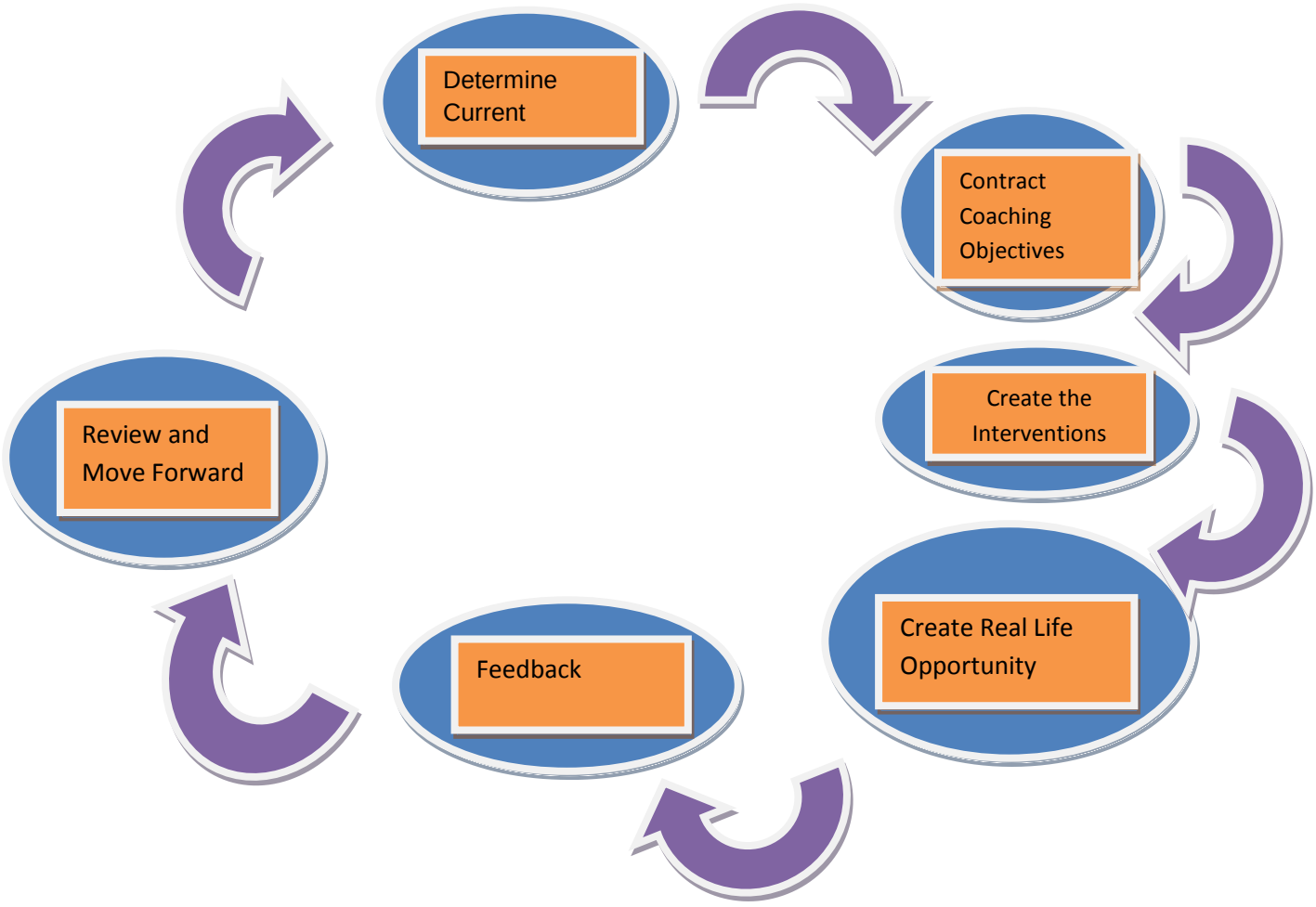


Primary Use: When there is only one right way to do the 'thing'

Secondary Use: To provide the skills acquisition elements of other coaching models.

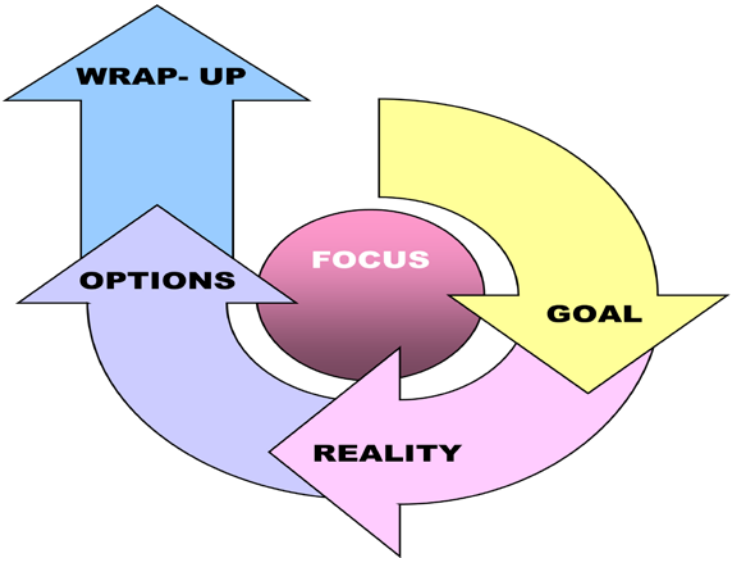
NOTES:

PERFORMANCE COACHING



NOTES:

GROW COACHING MODEL



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INTRODUCTION TO TEMPERAMENTS AND LEARNING

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Temperament

Learning

Temperament	Prefers to learn via:	Examples
Artisans - peacocks	Action Hands-on tasks Playfulness	Simulations On-the-job Games
Guardians - Owls	Structure Practical applications Organisation	Workshops Demonstrations Checklists
Rationals - eagles	Analysis Theory Independence	Debates Books by experts Special projects
Idealists - Doves	Personal touch Future focus Understanding	Small groups Imagery Role-playing

Feedback

Guardians - Owls • Proceed slowly • Ensure your facts and figures are correct • Give time for assimilation • Keep it task focused and do not personalize • Use precision • Formal setting may work best	Idealists - Doves • Understand that they will take all feedback personally and may be seem oversensitive • Assist them in a process of self-discovery and self-evaluation • Be careful of their tendency to self-efface • Use empathy • Informal setting may work best
Rationals - eagles • Be direct • Tell them how the feedback can make them more competent • Make sure of your details and examples • Formal setting may work best	Artisans - peacocks • Be direct • Tell them how the feedback can enhance their impact • Personalize the feedback • Don't dwell excessively on detail • Informal setting may work best

REFLECTIONS:

TIME MANAGEMENT

Calvary Health Care Sydney, Supervision of Students- Intermediate. Pilot program. In the tradition of the sisters of the Little Company of Mary with values of Hospitality, Healing, Stewardship & Respect. *This project was possible due to funding made available by Health Workforce Australia.*

TIME MANAGEMENT

Time Management Matrix

URGENT means it requires immediate action. They are usually visible, pressing and they insist on action. They are often not important.

IMPORTANCE has to do with results. If something is important it has to do with your mission, values, and high priority goals. Important matters that are not urgent require more initiative, more proactively.

CRISIS MANAGEMENT	PLANNED PROACTIVITY
High Importance High Urgency	High Importance Low Urgency
Low Importance High Urgency	Low Importance Low Urgency
URGENCY ADDICTION	TRIVIA

	URGENT	NOT URGENT
IMPORTANT		
NOT IMPORTANT		

	URGENT	NOT URGENT
IMPORTANT	**QUADRANT 1** CRISIS MANAGEMENT	**QUADRANT 2** PLANNED PROACTIVITY
NOT IMPORTANT	**QUADRANT 3** URGENCY ADDICTION	**QUADRANT 4** TRIVIA

Think back over the past week , if you were to place each of your last week's activities in one of these quadrants, where would you say you spend the majority of your time?

What is the one activity that you know if you did superbly well and consistently would have significant positive results in you work life?

Think of a typical week or fortnight and place your items/ activities in the chart. Experience has show that while Q 2 activities are important, people often fail to act on them because they are not urgent or pressing. More time and attention needs to be given to the items Q2 for long-term effectiveness.

Goal Setting

Action Planning

S

M

A

R

T

Perhaps: SMAAARRT

Goal Setting:

Action Steps:

S

M

A

R

T

1. What I will do differently that will help me achieve the goal?

2. Who would notice this change and how would they observe it?

NOTES:

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COMMUNICATION

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COMMUNICATION

Balancing, Advocacy and Inquiry

Communicating with influence to achieve results often requires skilful discussions. Conversations can solve problems, change beliefs, perceptions and actions. When we converse skilfully, we can help each other expand our thinking, act more compassionately and wisely, and learn more deeply. When we converse unskilfully, we can unwittingly confuse, obscure, manipulate, dominate, escalate conflict and tension.

Advocacy

Is about how ideas are presented and explained. It is primarily, one-way communication. When communication is only one-way it becomes difficult for the listener to understand the reasoning that supports the ideas being presented. This makes it less likely that people will commit themselves to any meaningful course of action. Before people will commit to a course of action they need to understand the reasoning behind the ideas. Advocacy is about making your point, taking a stand in an attempt to influence others, supporting your viewpoint with a rational – and relational – argument, whilst remaining open to alternative views.

Advocacy – Making your thinking more visible to others

- State your views
- Say why you think that (explicit reasoning)
- Give data supporting your view
- Give an example if possible
- Invite others to test your thinking

Inquiry

Is about how questions are raised and answered. Inquiry allows people to inquire into one another's reasoning and understand the conclusions they have reached. Inquiry helps us to understand what others are thinking and the reasoning behind their viewpoints.

When balancing advocacy and inquiry, we lay out our reasoning and thinking, and then encourage others to respond. "Here is my view and here is how I have arrived at it. How does it sound to you? Do you see any ways we can improve it?"

Advocacy alone is insufficient. Inquiry alone is insufficient. Learning to balance advocacy and inquiry increases two-way dialogue, understanding and commitment.

Inquiry – asking good questions

- What leads you to think that?
- What do you mean by that? Could you give me an example?
- Could you say more about that?
- How do you feel about that?
- What might the views of others be?
- What might the data of other s be that might lead them to think differently?
- What might you be missing by looking at the issues this way? By going in this direction?

COMMUNICATION

The Ladder of Inference:

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COMMUNICATION

Rapport via Neuro Linguistics

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COMMUNICATION

Exercise: Listening

While the other person is talking, how often do you.....			
	Often	Sometimes	Never
1. Rehearse what you are going to say			
2. Interrupt			
3. Wish they would get to the point quickly			
4. Mind read/guess what they are going to say			
5. Judge them & write them off			
6. Filter out some things e.g. Pay attention only to the facts			
7. Try to cut them off so you can get the discussion finished in a hurry			
8. Make assumptions			
9. Look away or check your watch or fidget			
10. Daydream – half listen			
11. Continue to work but try to reassure them by nodding & saying 'Please go on, I am listening'			
12. Identify with what they're saying and turn the conversation to you			
13. Tinker with your mobile/read SMS's.			

Compare your responses with others and discuss

1. The challenge of listening

2. Strategies to improve your listening

COMMUNICATION

Listening

Active Listening

The Words You Use

A major component of active listening is the actual words you use to convey to the other person that you are not only listening to them but also ***understanding*** what they are saying to you. The following are some examples that you can use to gain greater clarity of understanding and insight into the meaning of others communication:

The following are word sequences that you can use during the listening process when you *think* you understand the other person accurately:

· *"It seems to you that…"*

· *"You feel…"*

· *"In your experience…"*

· *"From where you stand…"*

· *"Your perception is that…"*

· *"You're…"* (Identify the feeling: sad, angry, upset, overjoyed)

· *"You believe…"*

· *"You mean…"*

· *"In other words…"*

· *"What you're saying is…"*

When you are *less sure* about what the other person is trying to say to you or the meaning they are trying to convey, try some of the following:

· *"Let me see if I understand you correctly, you feel…"*

· *"I get the impression that you…"*

· *"It appears as if…"*

· *"… … is that what you mean?"*

· *"Do you feel a bit…?"* (Identify the feeling: sad, angry, upset, overjoyed)

· *"Maybe I'm wrong but it seems as if…"*

· *"Is it possible that…"*

Source: Anne Kotzmann; Listen to Me Listen to You

I often ponder over the nature of true human sincerity, true transparency...It is a rare and difficult thing; and how much it depends on the person who is listening to us! There are those who pull down the barriers and make the way smooth; there are those who force the doors and enter our territory like invaders; there are those who barricade us in, shut us in upon ourselves, dig ditches and throw up walls around us; there are those who set us out of tune and listen only to our false notes; there are those for whom we always remain strangers, speaking an unknown tongue. And when it is our turn to listen, which of these are we…?" **- Anonymous**

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ASSESSMENT OF COMPETENCE

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ASSESSMENT OF CLINICAL SUPERVISION:

Assessment of clinical supervision takes two forms. One is assessment of the actual elements that are being supervised: the knowledge, skills and attitude of the supervisee.

Knowledge: How is this assessed in your practice?

Skills: How are these assessed in your practice?

Attitude: How is this assessed in your practice?

The second component to be assessed is the actual dynamics of the supervisor/supervisee relationship. For this assessment the world of mentoring offers a workable range of areas to be considered. The following is a standard mentor/mentee checklist that can be applied to clinical supervision. These check list can be used by both the supervisor and the supervisee.

Relationship Development

Instructions for completion

Tick a column for each item to indicate your view about whether or not you think you have reached this stage in your relationship with your clinical supervisee/supervisor.

Rapport-building	**SA**	**A**	**D**	**SD**
1. We have established a good understanding of each other				
2. I feel relaxed in meetings with my supervisee/supervisor.				
3. My supervisee/supervisor listens to me without evaluating				
4. My supervisee/supervisor is reliable				
5. We communicate on the same wavelength				
6. My supervisee/supervisor understands and respects my feelings				
7. My supervisee/supervisor understands and respects my opinions				
8. I believe that my supervisee/supervisor will respect the confidences I share with him/her				
9 I feel confident that the relationship is going to succeed				

Direction-setting	**SA**	**A**	**D**	**SD**
1. We have established clear goals for our relationship				
2. We have agreed our joint and individual objectives for the clinical supervision process				
3. We have agreed a broad route towards achieving our clinical supervision goals				
4. We have agreed ways to measure progress towards our clinical supervision objectives				
5. We have agreed a set of guidelines for the clinical supervision process				
6. We have developed a high degree of mutual respect				
7. We have achieved a mutual trust in one another				
8. We are willing to trust each other with personal confidences				
9. I am confident that my supervisee/supervisor is always totally honest and open with me				
10. The supervisee is confident to ask for help on any issue that arises				
11. The supervisee is confident that the supervisor will be willing to give help and/or advice as needed				
12. The supervisee is confident that the supervisor will be competent to give help and/or advice as needed				
13. We enjoy and expect to benefit from the time we spend together				
14. Our meetings are constructive and focused				
15. Our meetings are never rushed, interrupted or broken off				
16. It is rare for us to postpone meetings				

Progress-making and Maturation	**SA**	**A**	**D**	**SD**
1. Our meetings are more frequent now than when our relationship started				
2. The agenda for our meetings is being set increasingly by the supervisee				
3. The pace of our meetings is being set increasingly by the supervisee				
4. Responsibility for managing our relationship is resting increasingly with the supervisee				
5. The balance of power in our relationship is resting increasingly with the supervisee				
6. We are both fully committed to and enthusiastic about achieving the supervisory goals that we have agreed				
7. We have celebrated achievement of goals/milestones, and intend to continue to celebrate future achievements				
8. We re-define the goals and objectives of our relationship as often as we need to				
9. The supervisor is gaining a lot more from the relationship than when it first started				
10. We have a positive, supportive, nurturing relationship				
11. The supervisee is much more confident to cope with new or demanding situations than when our relationship began				
12. Discussing problems raised by either of us has become a natural part of our meetings				

13. I feel that both of us are learning through the relationship (i.e. we are achieving two way learning)				
14. The supervisee takes full advantage of all the learning opportunities created by the supervisor				
15. The supervisor can usually provide the right kind of example to help the supervisee's understanding				
16. The supervisee has learned how to allocate appropriate time (not too hasty or too long) to make judgments/decisions				
17. We are willing to criticize each other's behaviour but not to direct criticism personally				
18. The supervisee is comfortable at receiving constructive criticism from the supervisor				
19. We are comfortable at surfacing differences of opinion, and working through them constructively together				
20. We have learned to agree to disagree without being disagreeable				
21. We are prepared to argue about an issue, but in a constructive manner				
22. The supervisee feels comfortable to challenge or be critical of the supervisor				

Closedown/Termination	**SA**	**A**	**D**	**SD**
1. We have largely achieved all the goals we set for our relationship				
2. We can't think of any significant new topics of objectives we need to cover at the present time				
3. We sometimes struggle during meetings to find new issues to talk about				
4. The supervisee can now tackle most situations confidently, without needing the supervisor's help				
5. I feel that the supervisee has reached self-sufficiency, and could cope more than adequately if we ceased to meet				
6. We are in danger of getting dependent on each other for advice/guidance/support				
7. The supervisor quite often uses the supervisee as a sounding board for his/her own issues/problems/opportunities				
8. The supervisee can often predict what the supervisor will say next				
9. We meet together in (social) contexts as well as in formal supervisory meetings				
10. We have developed a mutual interest in one another's domestic situation and non-work activities				
11. We have become firm friends at a professional level				
12. We have developed a good personal friendship				

REFLECTION:

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