

TWELVE TIPS

Twelve tips for effective clinical supervision based on a narrative literature review and expert opinion

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Abstract

Background: Clinical supervision has gained wide recognition in recent years as an essential component of a practitioner's continuing professional development. However, confusion exists in professional literature regarding the most effective models, styles, processes and methods of clinical supervision.

Aim: This article outlines the elements required to establish and sustain an effective clinical supervision arrangement for health professionals, based on current evidence and the author's expert opinion.

Conclusion: A set of practical strategies are proposed to assist practitioners to establish an ongoing, effective clinical supervision partnership.

Introduction

The term clinical supervision has been used in a variety of ways. There is diversity in thinking about clinical supervision as it encompasses various ideas, different approaches and methods (Jones 2006). It has been acknowledged that the term clinical supervision itself is problematic as it is interpreted differently by different groups depending on the origin/historical use of the word, dynamic changes, relevance of the concept to different cultural groups, the language spoken and the meaning attached to this language (Walsh et al. 2003; Shanley & Stevenson 2006). Bogo and McKnight (2008) strongly recommend the use of consistent terms in regards to supervision in order to facilitate communication about this area. In this article, the term clinical supervision is defined as a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, and is acknowledged to be a life-long process (Edwards et al. 2005; Simpson & Sparkes 2008). This type of supervision involves reflective thinking, discussion regarding professional development issues, case-load, clinical issues, and staff interpersonal issues (Fone 2006). Therefore, the term clinical supervision in this article does not include supervision of subordinate personnel or assistants. Clinical supervision as defined here may be equated with terms such as "guided supervision," "professional supervision" or "intervention."

Clinical supervision is an essential component of a clinician's continuing professional development (Kilminster & Jolly 2000; Fone 2006; Herkt & Hocking 2007; Cox & Araoz 2009; Hall & Cox 2009). Clinical supervision differs from related activities, such as mentoring and coaching by

incorporating an evaluative component (Milne 2007). Mentoring is usually a voluntary, non-reporting relationship with a more experienced health professional while clinical supervision is non-voluntary as it is a requirement of many organisations and registration bodies (Strong 2008). On the other hand, coaching is used as a method for improving instruction and teaching strategies, experimenting with new approaches and techniques, problem solving, and building collegial relationships (Gallacher 1997).

Clinical supervision has been shown to benefit the practitioner, the patient and the organisation. For practitioners, the benefits of clinical supervision include supporting those working in isolation (Clough 2003), assisting practitioners to cope better with their work and workplace (Edwards et al. 2005), developing the competence and knowledge of the practitioner (Kleiser & Cox 2008) and reducing burn-out (Edwards et al. 2006). For patients, it has been suggested that supervision has a positive effect on patient outcomes and that a lack of supervision of health professionals can be harmful to patients (Kilminster & Jolly 2000; Farnan et al. 2012). There is general agreement that the purpose of supervision, whether stated or implied, is to improve the patient care experience (Kilminster & Jolly 2000; Spence et al. 2001). When established and conducted effectively, supervision is proposed to provide an environment in which clinicians can safely appraise their practice, develop professional skills, question established practices and seek new approaches, thus improving the standard of patient care (Hunter & Blair 1999; Farnan et al. 2012). For the organisation, supervision is described as improving multi-disciplinary teamwork, enabling the development of clinical standards and enhancing the quality of service delivery (Hunter & Blair 1999).

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Evidence suggests that irrespective of professional and theoretical background, supervisors engage in very similar supervisory practices (Rich 1993; Ladaney et al. 1999). There appear to be far more similarities than differences across many professional groups (such as social work, psychology, speech pathology and occupational therapy) in the aims, processes, and methods of supervision (Spence et al. 2001).

Despite the importance of clinical supervision to professional development and practice, there is a lack of research regarding how it is best conducted (Jones 2006). Furthermore, lack of awareness among practitioners regarding effective supervisory strategies has been said to lead to confusion regarding the supervision process (Sweeney et al. 2001a; Buus & Gonge 2009).

This article aims to outline some practical tips that would enable a practitioner to establish an effective clinical supervision partnership. As this review is based on literature from several disciplines including nursing, medicine, psychology, psychotherapy, counselling, social work, physiotherapy, occupational therapy and speech pathology, it is expected to address the needs of practitioners from multiple health professions.

Tip 1

Identifying a suitable clinical supervisor

Findings from a number of studies indicate that choosing one's own supervisor enhances the quality of the supervisory relationship and hence promotes the overall quality and effectiveness of clinical supervision (Sweeney et al. 2001a; Edwards et al. 2005; Cutcliffe & Hyrkas 2006; Hall & Cox 2009). This is related to the finding that choosing one's own supervisor enhances the trust and rapport between the supervisor and the supervisee (Edwards et al. 2005).

Tip 2

Deciding on the most suitable type of supervision

Three types of clinical supervision delivery often cited in the literature are one-to-one supervision, peer group supervision or a combination of both (Edwards et al. 2006; Horton et al. 2008; Cox & Araoz 2009). There are mixed views in the literature regarding the preferred type of supervision (Spence et al. 2001; Abbott et al. 2006; Clough 2003). The preferred type of supervision tends to vary according to the discipline, with some disciplines such as occupational therapy and psychology traditionally preferring the one-to-one method (Cox & Araoz 2009; Palomo et al. 2010) and disciplines such as speech-and-language therapy preferring the group method (Horton et al. 2008).

Peer supervision is different from one-to-one supervision and emphasises mutual respect and collegial support (Spence et al. 2001). Winstanley and White (2003) surveyed over 1000 respondents in the UK and found that supervisees in group sessions felt that the advice and support given by their supervisor was more effective than supervisees receiving clinical supervision in a one-to-one situation. In a study of 260

nurses in the UK, Edwards et al. (2005) found that the type of clinical supervision received did not impact on the effectiveness of clinical supervision. Peer supervision is said to be appropriate for experienced practitioners, staff for whom a senior is unavailable, or when used as an adjunct to one-to-one supervision (Spence et al. 2001).

It therefore appears that the important considerations for practitioners when deciding upon the most suitable type of supervision are their experience within the profession, their experience in the specific clinical role they are assuming and the remoteness of their location.

Tip 3

Establishing a supervision agreement/contract and using a supervision agenda

Utilising a supervision agreement or contract is promoted as a key component of an effective supervision process (Hunter & Blair, 1999; Sweeney et al. 2001a; Herkt & Hocking 2007; Gaitskell & Morley 2008). A supervision contract, negotiated between supervisor and supervisee, is used to form the boundaries within which both parties can work within. Using a contract helps both parties to be aware of their expectations, to examine respective hopes and fears for the relationship and to negotiate supervision needs. Specific details such as venue, frequency, duration, professional accountability and confidentiality can also be documented. It is recommended that such a contract is completed by the supervisee and supervisor collaboratively (Hunter & Blair 1999; Sweeney et al. 2001c; Clough 2003; Fone 2006).

Maintaining records of supervision meetings and outcomes is also considered an important part of the supervision process. Meeting agendas need to be set by the supervisee in consultation with the supervisor, linking the content to the supervision contract (Spence et al. 2001).

Tip 4

Choosing a venue away from the supervisee's workplace to conduct supervision sessions

Use of unsuitable space in clinical areas, or holding meetings too close to work units, have been shown to increase the likelihood of being interrupted, thus impeding the successful implementation of clinical supervision (Gilmore 2001). A survey of the perceptions of 260 nurses indicated that the level of rapport with the supervisor was higher and reflective practice of the supervisee better if the sessions were held away from the workplace (Edwards et al. 2005). In addition, having sessions away from the workplace increased the tendency of the supervisee to discuss issues of a sensitive and confidential nature. The supervisees in this study felt more supported whilst reflecting on complex clinical scenarios when sessions were held away from their usual workplace (Edwards et al. 2005).

Tip 5

Deciding on the optimal meeting length and frequency

Recommendations made by experts in the field of clinical supervision include scheduling supervision sessions regularly and for a sufficient length of time to be effective (Edwards et al. 2005; Cox & Araoz 2009). In a study of social workers (Kilminster & Jolly 2000), the amount of supervision received was significantly correlated with supervisee satisfaction with supervision. A study of mental health professionals in Queensland (Kavanagh et al. 2003), found that supervision frequency had a positive relationship with the perceived impact of supervision on clinical practice, particularly when the supervisor was from the same discipline ($r=0.28$, $p < 0.001$).

Butterworth et al. (1997) recommended that clinical supervision sessions should occur for no less than 45 min every four weeks. Winstanley (2003) recommended that each clinical supervision session should be a maximum of one hour for hospital-based nursing staff in order for it to be of use, whereas for community-based nursing staff extending sessions to more than one hour was needed to be perceived beneficial by the supervisee. Edwards et al. (2005), in their study of 260 community nurses using the Manchester Clinical Supervision Scale, found that supervisees whose sessions lasted for over an hour in length achieved the highest score on the measure.

Most individual organisations and professional regulating bodies have recommended supervision implementation standards and guidelines (e.g. Making a difference: clinical supervision in primary care, Department of Health, London 2000; Queensland Health allied health professional support guidelines, 2012; American Occupational Therapy Association's guide for supervision of occupational therapy personnel, AOTA 2004). Many of these guidelines contain minimum requirements which are to be met by employees. It is recommended that those with lesser experience, those newer to their role, and those working in isolation will benefit from more frequent, longer supervision sessions, compared to those who are experienced in their role and well-networked.

Tip 6

Using effective communication and feedback

Feedback is a two-way interaction and is a critical component of any successful supervisory relationship (Sweeney et al. 2001c; Gaitskell & Morley 2008; Fowler 2011). Giving and receiving constructive feedback on a regular basis has been cited as the most powerful but underused strategy in supervision (Hunter & Blair 1999). To be effective, feedback should be clear, regular, balanced with both positive and constructive elements, non-threatening, and specific (Sweeney et al. 2001c; Cox & Araoz 2009). In addition to the supervisor giving feedback on the supervisee's performance, the supervisor should request and respond to feedback from the supervisee

about the process of supervision, his/her style as a supervisor, and the content and climate of supervision sessions (Sweeney et al. 2001c). In a study of 18 therapists conducted in the UK, audio-taped therapy sessions of the supervisee conducting client assessment or treatment sessions have been shown to be of use to assist the supervisor in providing feedback about the supervisee's performance (Cox & Araoz 2009).

Tip 7

Facilitating reflective practice

Reflective practice is an integral part of effective clinical supervision and is part of the normative or educative function of clinical supervision. Normative function is a component of the tripartite model of supervision described by Proctor. This includes discussion regarding the norms, the policies and the procedures of the workplace. It can also include education regarding the professional standards and ethics (Clough 2003; Richardson et al. 2003; Winstanley & White 2003; Herkt & Hocking 2007; Simpson & Sparkes 2008; Cox & Araoz 2009; Hall & Cox 2009; Fowler 2011). In a study conducted by Cox and Araoz (2009) with therapists in the UK, 86% of the participants reported using reflective practice within their supervision sessions. Results from another study of 558 nurses in the UK showed that participants expected that clinical supervision would take on a reflective nature: 89% reported that clinical supervision that involved reflective practice would help them to focus on and improve patient care; 91% thought it would help them focus on their strengths; and, 90% thought it would help them focus on their weaknesses (Fowler & Chevannes 1998).

Reflective practice is enhanced by the use of specific reflective processes, logs, diaries, the exchange of ideas, dialogue and discussion (Cox & Araoz 2009). Reflective practice also involves thinking through previous events, experiences and ideas; and writing them down (Hall & Cox 2009).

For the experienced practitioner, reflecting on their practice may be easy for routine tasks (Fowler 1998). In a study of experienced occupational therapists, Herkt and Hocking (2007) found that reflective practice in supervision was used by some therapists as an opportunity to raise their self-awareness. For the supervisee with minimal experience, reflective skills may need to be developed. Supervisors are encouraged to direct supervision sessions and to facilitate supervisee's reflection to avoid supervisee frustration that may arise from not being able to reflect spontaneously (Fowler & Chevannes 1998).

Fone (2006) describes some practical strategies to assist the supervisor in facilitating reflective thinking of the supervisee. These include encouraging the supervisee to complete self-appraisal and debriefing; asking the supervisee what led them to making a decision and what they could have done differently; asking the supervisee to verbalise a sequence of thoughts and decisions; paraphrasing what the supervisee says; and encouraging the supervisee to practise verbalising clinical reasoning.

Tip 8

Considering use of more than one mode for distance clinical supervision

Literature reports the use of both face-to-face and distance supervision methods. Face-to-face supervision can include observation, modelling, co-treatment, discussion, teaching and instruction (Sweeney et al. 2001a). Many of these methods are difficult to engage in during distance supervision which can be via tele-conference, video-conference, e-mail and other computer-based technologies. Distance from supervisors is perceived by supervisees as a barrier to effective supervision, with some studies reporting a strong preference for face-to-face delivery (Clough 2003; Kavanagh et al. 2003; Cox & Araoz 2009).

Lack of face-to-face supervision is a particular issue in countries with a large geographical area and a relatively small and dispersed population, such as Australia (Spence et al. 2001). This is due to the shortage of qualified practitioners in regional, rural and remote areas (Spence et al. 2001; Kavanagh et al. 2003). Given the nature of distance supervision, with lack of face-to-face contact making it less desirable, it would appear that more than one mode of contact may be necessary. While further research is required to determine the effectiveness of supervision using computer-based technologies, video-conferencing and tele-conferencing (Spence et al. 2001), the first author recommends the use of more than one mode for distance supervision where possible. This recommendation is based on the health service process evaluation and the first author's experience supervising practitioners from a distance in regional and rural Queensland. In the initial phase of establishing the supervision relationship, alternating tele-conferencing with video-conferencing (when available), helps to break down barriers and to improve rapport between the supervisee and supervisor. Making use of other opportunities (e.g. attending a workshop or a conference) to meet face-to-face with the supervisor/supervisee is also recommended.

Tip 9

Building a positive supervisory relationship

A good supervisory relationship is described in the literature as one that is positive, supportive, trustworthy, non-judgemental and encouraging (Hunter & Blair 1999; Spence et al. 2001; Herkt & Hocking 2007; Hall & Cox 2009). Empirical studies have identified that the quality of the supervisory relationship is the single most important factor for effective supervision (Hunter & Blair 1999; Kilminster & Jolly 2000; Spence et al. 2001; Kavanagh et al. 2003; Herkt & Hocking 2007; Cox & Araoz 2009; Karpenko & Gidycz 2012). These findings have been consistent across professions including social work, psychology, psychotherapy, occupational therapy and nursing (Hunter & Blair 1999; Kilminster & Jolly 2000; Spence et al. 2001; Kavanagh et al. 2003; Herkt & Hocking 2007; Cox & Araoz 2009). A particularly important feature of the supervisory relationship which emerged from a study

of the perceptions of allied mental health practitioners in Queensland is the positivity of the supervisory relationship, which involves mutual respect for each other (Kavanagh et al. 2003).

A wide range of ineffective supervisory behaviours have been described in the literature as barriers to a positive supervision relationship. These behaviours include rigidity, failure to consistently track supervisee concerns, failure to teach or instruct, being indirect and intolerant, being closed, lacking respect for differences, being sexist; and emphasising evaluation, weakness and deficiencies (Kilminster & Jolly 2000; Spence et al. 2001). Being non-collegial, lacking in praise and encouragement and providing low empathy and support have also been described as ineffective behaviours that act as barriers to a positive supervision relationship (Kilminster & Jolly 2000; Spence et al. 2001). Clinical supervisors who are inconsistent, overly demanding, condescending, uncaring, or disrespectful have been shown to impede learning in the clinical setting (Plack 2008). In addition, a study of occupational therapists by Sweeney et al. (2001a) identified that a lack of disclosure of practice issues by supervisees, such as not feeling confident in administering a particular test or completing an assessment, as a barrier from the supervisor perspective.

Tip 10

Separating clinical supervision from line management

Clinical supervision is complementary to, yet separate from, other forms of supervision (e.g. managerial supervision or line management) (Winstanley 2000). There has been much debate in the literature regarding the effectiveness of clinical supervision provided by a line manager (Spence et al. 2001; Sweeney et al. 2001a,b,c; Landmark et al. 2003; Abbott et al. 2006; Herkt & Hocking 2007; Kleiser & Cox 2008). A critical literature review on the integration of clinical and managerial supervision by Kleiser and Cox (2008) found that some authors acknowledge that managers can operate effectively as supervisors. However, when line management and clinical supervision is provided by the same person, evidence suggests that supervision time is frequently taken up in discussion of administrative issues, rather than clinical matters (Spence et al. 2001; Kleiser & Cox 2008).

In some instances, administrative supervision/line management is linked to performance evaluation of the employee. When this happens, there are a range of ethical and practical issues surrounding this combination of roles (Spence et al. 2001; Herkt & Hocking 2007). For example, in a study of occupational therapists by Herkt and Hocking (2007), practitioners who were clinically supervised by their line managers constantly raised the issue of power imbalance in the supervision relationship. They expressed concerns about being seen as incompetent if they discussed issues regarding their work skills and performance. This influenced what concerns the occupational therapists mentioned in supervision as they felt that disclosure of perceived incompetency or performance below an expected standard would impact on them within the workforce. These supervisees used a range of

actions termed as “guarding,” where they consciously or unconsciously protected themselves using cognitive avoidance strategies or by physically avoiding supervision. The results of this study further suggested that when participants used guarding, there was a strong negative impact on the supervision outcome. That is, if the supervisee did not disclose issues of perceived incompetence, an opportunity to reflect and learn was lost. This leads to a poor supervision outcome as well as supervisee frustration as issues meaningful to the supervisee are neither discussed nor resolved. Cutcliffe and Hyrkas (2006) reported that of 74 multi-disciplinary health professionals in the US, 90% of the participants held the attitude that their supervisor should not also be their line manager.

Where individual circumstances/organisational processes do not permit access to a clinical supervisor who is different to the line manager, it is recommended that supervision issues be clearly separated from line management issues. A clearly-structured supervision contract outlining separate clinical supervision and managerial agendas is recommended. Regular reviews and feedback from the supervisee are crucial in such arrangements.

Tip 11

Undertaking training in supervision

Different ways of learning about clinical supervision include reading books and articles on supervision, reflecting on the supervision provided and received or completing a training course on supervision (Geller & Foley 2009). Of these methods, completing a training course on clinical supervision has been the most frequently cited method in the literature of building supervision skills (Hunter & Blair 1999; Kilminster & Jolly 2000; Spence et al. 2001; Sweeney et al. 2001c; Gaitskell & Morley 2008).

Training in clinical supervision for both the supervisee and the supervisor may maximize the use of the clinical supervision process (e.g. the supervisor and supervisee are likely to become aware of the best practice guidelines in regards to effective clinical supervision). In addition, training may assist both parties in keeping up to date with evidence regarding effective clinical supervision practices (Hunter & Blair 1999; Kilminster & Jolly 2000; Spence et al. 2001; Sweeney et al. 2001c; Gaitskell & Morley 2008).

For the supervisee, training aims to enable the supervisee to understand how best to receive supervision, to increase awareness of the issues that can potentially have an impact on supervision and to provide an awareness of the demands on and the limitations of the supervisor. In addition, training also aims to provide clarification of the supervisee's own needs and expectations; to promote an understanding of the role, function, strategies and techniques of supervision, and to provide an introduction to appropriate theoretical and practice-led literature on supervision (Sweeney et al. 2001c).

Lack of training in supervision and a lack of exposure to theoretical models of supervision is said to contribute to confusion regarding the supervision process in disciplines such as occupational therapy (Sweeney et al. 2001c). A study

of senior medical consultants in Norway found that training positively affected motivation, increased awareness about learning needs and increased interpersonal and communication skills within the supervision process (Lycke et al. 1998). Although many authors describe the importance of training, a systematic review on translation of knowledge strategies by Scott et al. (2012) suggests that training can be ineffective in changing behaviour. This emphasises the importance of reflective practice in combination with training.

Tip 12

Evaluating clinical supervision

Evaluation of the supervision offered and received is integral to ensuring that supervision sessions are effective. A range of formal and informal methods can be used to evaluate clinical supervision (Jones 2006). Formal evaluation methods that have been reported in the literature include focus group interviews, semi-structured interviews and self-report questionnaires (Winstanley & White 2003). Tools are available to measure a number of different aspects of clinical supervision, including the quality and effectiveness of clinical supervision (e.g. Manchester Clinical Supervision Scale), the supervisory relationship (e.g. Supervisory Relationship Questionnaire) and the supervisory style (e.g. The Supervisory Styles Inventory). Discipline-specific tools are also available such as the Nursing in Context Questionnaire for nurses and Clinical Supervision Evaluation Questionnaire for Speech and Language Therapists. Some of the most widely cited clinical supervision measurement tools are the Manchester Clinical Supervision Scale (Winstanley 2000), the Clinical Supervision Evaluation Questionnaire (Horton et al. 2008) and the Supervision Attitude Scale (Kavanagh et al. 2003).

Informal methods of evaluating clinical supervision include the use of feedback and regular reviews. It is recommended that supervisees and supervisors evaluate their sessions on a regular basis. Factors such as the style of supervision, whether the needs of the supervisee are being met, the effectiveness of feedback provided and the nature of the supervisory relationship, should be evaluated. This should be followed by changes to the clinical supervision contract or arrangement if required.

Conclusions

Clinical supervision has been adopted by various disciplines as a means to support health practitioners as well as to uphold the quality of patient care. Based on research findings to date and the authors own experience supervising practitioners, this article outlines practical guidelines to assist practitioners to set up an ongoing effective clinical supervision arrangement.

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