POSITION STATEMENT
CLINICAL SUPERVISION FOR NURSES & MIDWIVES

Clinical Supervision for Nurses & Midwives

POSITION STATEMENT

KEY STATEMENT

Clinical Supervision is increasingly recognised as a core component of professional support for contemporary nursing and midwifery practice.[1] There is consistent evidence that effective Clinical Supervision impacts positively on the professional development as well as the health and wellbeing of supervisees.[2-16] The health and wellbeing of nurses and midwives is vital for recruitment and retention and ultimately a healthy and sustainable workforce. There is also emerging evidence that Clinical Supervision of health-care staff impacts positively on outcomes for service-users.[17-19]

DEFINITION

Clinical Supervision is a formally structured professional arrangement between a supervisor and one or more supervisees. It is a purposely constructed regular meeting that provides for critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice. Clinical Supervision facilitates development of reflective practice and the professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace.

Clinical Supervision as it is understood in this Position Statement is distinct from Point of Care Supervision, Facilitated Professional Development, Professional Supervision, Operational Management Processes, Clinical Management Processes, and Personal Staff Support.

A trusting alliance between the supervisee(s) and supervisor is the central element of effective Clinical Supervision. To develop and maintain this alliance Clinical Supervision:

◆ is conducted in regular, private and protected time, away from the practice setting;

◆ has effective communication and feedback at its core, is supportive, facilitative and focused on the work issues brought to the session by the supervisee(s);

◆ is an opportunity to talk about the realities, challenges and rewards of practice and to be attentively heard and understood by another professional;

◆ facilitates supervisee self-monitoring and self-accountability and involves the supervisee learning to be a reflective practitioner;

◆ is predictable and consistent with thoughtful and clear structures, boundaries, processes and goals;

◆ develops knowledge and confidence with a strengths-focus aimed at building supervisee practice skills and awareness of practice;

◆ is a culturally safe and respectful relationship that has commitment from both the supervisor and supervisee(s);

◆ is supported by an agreement that is reviewed regularly and includes the extent and limits of confidentiality;

◆ is confidential within the ethical and legal boundaries of nursing and midwifery practice;

◆ supports supervisees to choose their supervisors;

◆ is provided by professionals who have undertaken specific training in Clinical Supervision and engage in their own regular Clinical Supervision;

◆ is not provided by a professional who has organisational responsibility to direct, coordinate or evaluate the performance of the supervisee(s).

POSITION STATEMENT

It is the position of the Australian College of Nursing, the Australian College of Mental Health Nurses and the Australian College of Midwives that Clinical Supervision is recommended for all nurses and midwives irrespective of their specific role, area of practice and years of experience.

TO ACHIEVE THIS POSITION, IT IS RECOMMENDED THAT:

1. Clinical Supervision is embedded in all nursing and midwifery undergraduate and vocational education as a component of professional practice.

2. All nurses and midwives are fully orientated to Clinical Supervision upon entry to their relevant workforce and have access to Clinical Supervision that meets their individual needs.

3. All Clinical Supervisors of individuals and groups undertake specific educational preparation for this role and engage in their own regular Clinical Supervision.

4. The nursing and midwifery professional bodies advocate for a national standard for educational preparation of Clinical Supervisors.

5. All employers of nurses and midwives positively support and actively promote quality Clinical Supervision through organisational policies, procedures and workplace culture.

6. Regular systematic evaluations of the quality and efficacy of Clinical Supervision arrangements are undertaken at the local service level, taking care not to compromise the integrity of confidentiality agreements between supervisors and supervisees.

7. The nursing and midwifery professional bodies advocate for investment in robust Clinical Supervision programs throughout the health and aged care systems to support implementation and sustainability.

8. The nursing and midwifery professional bodies advocate for investment in outcomes-related research to strengthen the Clinical Supervision evidence base and for continuous improvement.

9. The nursing and midwifery professional bodies collaborate with industrial associations to incorporate Clinical Supervision within Enterprise Bargaining Agreements.

10. The nursing and midwifery professional bodies take an active role in interdisciplinary collaboration and advocacy for Clinical Supervision.

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Clinical Supervision for Nurses & Midwives

BACKGROUND PAPER

Clinical Supervision has an established history in health-care professions including psychotherapy, counselling, social work, psychology and psychiatry.[1] North American nurses began developing their ideas as early as 1925[2] and the nursing literature in relation to Clinical Supervision has grown significantly.[3] The literature base from all disciplines is now extensive.[4, 5]

Clinical Supervision has been a regular focus of discourse in relation to mental health nursing and it is increasingly being regarded as important for all nurses and midwives regardless of what area, role, level or model of care they work in.[3, 5-17] The capacity to reflect on practice is a desired aspect of nursing and midwifery[18] and has been identified as a core characteristic of the expert nurse and midwife.[19] Reflection and Clinical Supervision is referenced in key documents related to nurses and midwives.[20-32]

TERMINOLOGY

It is acknowledged that the term *Clinical Supervision* has been identified as problematic as it can be interpreted and applied in different ways.[33, 34] Alternative terms have been offered in the literature[35-37] but they do not provide adequate distinction from other activities and can equally be misunderstood. This Position Statement uses the term *Clinical Supervision* in the absence of a term that successfully reduces confusion and conveys the essence of the process.[33]

Clinical Supervision is a formally structured professional arrangement between a supervisor and one or more supervisees. It is a purposely constructed regular meeting that provides for critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice. Clinical Supervision facilitates development of reflective practice and the professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace.

Clinical Supervision as it is understood in this Position Statement is distinct from Point of Care Supervision,[20] Facilitated Professional Development,[20] Professional Supervision,[33] Operational Management Processes,[33, 38, 39] Clinical Management Processes,[28, 29] and Personal Staff Support.[37, 40, 41]

MODES AND MODELS

MODES

Clinical Supervision can be conducted via a range of modes. It can be delivered through face-to-face meetings in dyads (one-to-one) or small groups (6-8 supervisees) and with advances in technology via telephone, video-conference[42] and e-supervision.[43]

MODELS

Within Clinical Supervision practice there are two main groups of models: psychotherapy-based models and supervision-specific models.[44] Psychotherapy-based models utilise the assumptions and techniques embedded in a psychotherapeutic approach to guide Clinical Supervision. Supervision-specific models have been developed over time through Clinical Supervision programs for the helping professions.[44] While models of practice vary within and between professional groups and practice settings,[7, 11, 45] they are all "…grounded in theories and practices common to all".[46 (p.89)]

This Position Statement does not preference a mode or model of Clinical Supervision as there is no evidence for the superiority of any approach.[35]

COMPONENTS OF EFFECTIVE CLINICAL SUPERVISION

There is substantial evidence that a trusting professional alliance between the supervisor and supervisee(s)[35, 40, 46-54] is the core element of effective Clinical Supervision. The following components contribute to the development and maintenance of this alliance[3, 4, 12, 14, 15, 20, 34, 35, 37, 40-42, 48, 49, 51, 55-64] and underpin effective Clinical Supervision.

Clinical Supervision:

◆ is conducted in regular, private and protected time, away from the practice setting;

◆ has effective communication and feedback at its core, is supportive, facilitative and focused on the work issues brought to the session by the supervisee(s);

◆ is an opportunity to talk about the realities, challenges and rewards of practice and to be attentively heard and understood by another professional;

◆ facilitates supervisee self-monitoring and self-accountability and involves the supervisee learning to be a reflective practitioner;

◆ is predictable and consistent with thoughtful and clear structures, boundaries, processes and goals;

◆ develops knowledge and confidence with a strengths-focus aimed at building supervisee practice skills and awareness of practice;

◆ is a culturally safe and respectful relationship that has commitment from both the supervisor and supervisee(s);

◆ is supported by an agreement that is reviewed regularly and includes the extent and limits of confidentiality;

◆ is confidential within the ethical and legal boundaries of nursing and midwifery practice;[64, 65]

◆ supports supervisees to choose their supervisors;

◆ is provided by professionals who have undertaken specific training in Clinical Supervision and engage in their own regular Clinical Supervision;

◆ is not provided by a professional who has organisational responsibility to direct, coordinate or evaluate the performance of the supervisee(s).

OUTCOMES

OUTCOMES FOR SUPERVISEES

A substantial literature base on Clinical Supervision has accumulated over many years with numerous evaluation studies conducted in a range of settings. These studies are predominantly qualitative but more quantitative and mixed-method studies are emerging with many of the findings consistent over time.[3] Surveys, evaluation scales, focus groups and semi-structured interviews have been used to evaluate the impact of both individual and group Clinical Supervision on supervisees.[3, 6, 8-10, 13, 14, 42, 51, 59, 60, 63, 66-69] The benefits to supervisees are summarised as follows:

◆ Increased self-awareness including insights into the use of self in the work.

◆ Increased ability to listen, be supportive and empathetic to service-users.

◆ Development and utilisation of skills and development of deeper theoretical knowledge.

◆ Increased competence, confidence, self-efficacy and professional accountability.

◆ Increased sense of empowerment and autonomy.

◆ Supported idea generation, creativity, innovation, problem solving and solution generation.

◆ Improved understanding of professional, moral and ethical issues.

◆ Role clarity and a stronger sense of professional identity.

◆ Increased critical thinking, critiquing and improving practice including risk management.

◆ Increased commitment to the organisation.

◆ Improved coping at work and general well-being; improved identification of, and access to supports; and reduced stress, anxiety and burnout.

◆ Feeling supported by having thoughts and feelings listened to.

◆ Increased interest and engagement in work, job satisfaction, personal accomplishment and development.

◆ Improved collegiate relationships (including with managers) and reduced conflict, a sense of community and increased trust.

Group Clinical Supervision is often seen as cost-effective and pragmatic for inpatient and team settings and it can work very well. However, it is important to recognise that Clinical Supervision in these settings can be challenging given the busy work environments where workload pressures, team dynamics, the changing group composition and the lack of option for self-selection into a group impact on the quality of Clinical Supervision. Anxiety can be experienced more intensely in a group, particularly in the early stages.[70, 71]

Negative experiences have been reported in both group and individual Clinical Supervision and include lack of trust, intrusiveness, unintended disclosure of personal information, breaches of confidentiality, bullying, feelings of doubt and vulnerability, shame, fear of judgement and being seen as not coping, and frustration with the loss of focus on the client.[7, 9, 72-79]

Negative experiences of Clinical Supervision have been associated with poor supervisory relationships, absence of key competencies within supervisors and lack of distinction between Clinical Supervision and operational processes.[46, 50, 78, 80] Ineffective or inadequate Clinical Supervision can be counterproductive, detrimental to development, unethical, and harmful to supervisees.[46, 50, 56, 80-82] It is important to note that negative or neutral outcomes of Clinical Supervision have been reported but to a significantly lesser degree than positive outcomes.[3, 9]

OUTCOMES FOR SERVICE-USERS

Determining the links between Clinical Supervision and improved outcomes for service-users is a challenging research undertaking. Some argue that improvements to the care of service-users will result when care is provided by nurses and midwives that are "...more patient-focused, and more sensitive to patient dignity... with increased job satisfaction and fewer sick days"[9 (p.270)] Clinical supervisees support this position perceiving that Clinical Supervision facilitates their ability to critique and improve practice, strengthen their relationships with service-users and to better understand family dynamics[8, 59, 83]. While, this needs to be verified, some progress has been made. It has been found that Clinical Supervision "...can play a role in developing the working alliance and enhancing treatment outcome"[84 (p.327)] for people with depression receiving counselling from supervised therapists. Another study found that an adult mental health facility with embedded effective Clinical Supervision processes that were supported by management was linked with increased service-user satisfaction with the care and the quality of the unit.[85] It has also been found that the severity of positive symptoms of people with schizophrenia decreased significantly more in the group being cared for by mental health nurses who received Clinical Supervision compared to a group cared for by mental health nurses who did not have Clinical Supervision as part of their Psychosocial Intervention training course.[86]

OUTCOMES FOR ORGANISATIONS

Broader organisational benefits have also been found. These include improved service-user feedback, fewer complaints, improved worker effectiveness, a positive impact on staff retention and improved multi-disciplinary teamwork.[67, 83, 85, 87-94]

ORIENTATION, EDUCATION AND TRAINING

To embed Clinical Supervision into nursing and midwifery practice, students need to be introduced to the concept early in their education as part of a suite of strategies that support them in their professional lives. For nurses and midwives to make the most of their supervisory experiences, they need to be educated on how to be a supervisee, what Clinical Supervision is and is not, and how to use and evaluate Clinical Supervision. Being a supervisee is not a passive role [41] and

supervisees need to be orientated to their rights and responsibilities and what they can expect from a supervisor. On entry to the workforce, nurses and midwives also need to be orientated to local policy and procedures.[12, 14, 28, 41, 42, 49, 73, 85, 95-100]

Particular skills, knowledge and attributes have been repeatedly associated with effective individual and group Clinical Supervision[12, 37, 41, 46, 47, 49, 50, 73, 94, 101-104] and it is agreed that supervisors require specific training programs in order to practice.[9, 14, 42, 85, 105-108] Without training, the Clinical Supervision provided is more likely to be inadequate, counterproductive or harmful.[46] Supervisees who receive poor Clinical Supervision are then likely to model their supervisory practice on their own supervisory experiences and become poor supervisors themselves.[47, 109]

It has been proposed that training methods should be delivered in a supportive manner[110] and include a mix of didactic delivery, experiential learning, simulated experience and Clinical Supervision practice within the training group.[111] However content of training has been found to vary significantly[111] with no national standard for educational preparation of Clinical Supervisors. In the absence of this, the best available guidance on content can be taken from resources[38, 110, 112] and texts on Clinical Supervision.[37, 40, 41, 49, 54, 113]

Supervisors also need to make sure they maintain their own Clinical Supervision to provide quality Clinical Supervision. It is their responsibility to receive their own regular Clinical Supervision[40] so they can receive professional support for the work they do, be a role model and build their own competency in the provision of Clinical Supervision.[41] Supervisors within organisations should be supported by the organisation to attend their own regular Clinical Supervision.[38]

IMPLEMENTATION

There is overwhelming consensus in the literature that strong and consistent organisational support must be provided for successful implementation of Clinical Supervision[9, 34, 37, 40, 41, 98, 114] so that Clinical Supervision is accepted as a dominant feature of the organisational culture. Any implementation strategy must be adequately resourced initially and on an ongoing basis with adequate allocation of budget and access to expertise[41, 94, 115]. Positive support for Clinical Supervision should be evident at all levels of the organisation with clear policies and procedures, dedicated information systems and documentation processes, a positive expectation for all staff to engage in Clinical Supervision and importantly, supported rostering to facilitate staff attendance at both Clinical Supervision[85] and Clinical Supervision training.

Implementation strategies must be considered carefully and for additional guidance, it is recommended that the synthesis of the literature on the implementation of Clinical Supervision developed in New Zealand be reviewed.[34]

EVALUATION AND RESEARCH

EVALUATION

Evaluation processes need to be embedded as part of the Clinical Supervision implementation strategy. Both formal and informal evaluation is recommended at a supervisor-supervisee level.[42] Time frames for formal review should be included in the agreement to ensure the Clinical Supervision relationship remains effective.[38]

Implementation of Clinical Supervision is a continuous process.[34] So too, is the evaluation of the effectiveness of implementation against locally agreed measures[41] to ensure the quality and efficacy of local Clinical Supervision arrangements are able to be demonstrated and regularly reported.[85] Evaluation can ascertain the perspectives of supervisees, supervisors and management[41] through surveys, research tools, interviews or focus groups.[14, 34, 42, 116, 117] Determining engagement of the workforce with Clinical Supervision can be partly ascertained through record audits such as numbers receiving Clinical Supervision, how often and for how long.[41, 85] Economic benefits can be evaluated through reviewing sick or stress leave, work cover, retention and critical incidents.[41] Finally benefits to practice may be found through reviewing service-user satisfaction and complaints.[41]

RESEARCH

Criticism of the quality of the research into Clinical Supervision has been highlighted.[6-8, 10, 11, 13-15, 35, 59, 60, 67, 85, 118] This is not surprising given Clinical Supervision is complex and there are a multitude of confounding variables that make research very challenging[6, 60, 67] and

> as a result of the complexity and diversity of the contexts in which it is implemented, the literature reports confusion about the role and structure of clinical supervision; a diffuse unlinked evidence base; challenges measuring the effectiveness of clinical supervision and difficulty in implementing clinical supervision in practice.[6 (p.22)]

The research rigor is limited by the lack of common denominators and detail regarding the structure and process of Clinical Supervision. For example, definitions, goals, models, session content, supervisee and supervisor training, what phenomena are examined, study context, implementation processes and research instruments used[3, 6, 11, 15, 119-123] are often not described well. This means making comparisons and reaching definitive conclusions is difficult.

While robust Clinical Supervision research will continue to be difficult to design, conduct, interpret and fund,[69] this challenge must be met through lobbying for and undertaking of adequately funded, well-constructed research that identifies the structure, process and outcomes of Clinical Supervision.[56, 123] Outcome orientated research must include outcomes for those who use the services of the supervisees, for the supervisees themselves as well as for organisations and the profession.[123] Without further small and large-scale studies in a variety of settings that examine the emerging theoretical propositions, the circular debates within the Clinical Supervision discourse will continue. We need to understand why Clinical Supervision "...as a supportive device has attracted more attention than any other"[9 (p.270)] and what it is about Clinical Supervision that keeps professions advocating its benefits. For this to occur, funding agencies, academia, clinicians and organisations need to consolidate efforts to improve the evidence base for Clinical Supervision.

GLOSSARY

POINT OF CARE SUPERVISION

Clinical Teaching: is the process of developing and sharing professional knowledge. It is the opportunity for an experienced clinician to transfer knowledge and skills to one who has less understanding in that clinical area. It is a key responsibility of every nurse and midwife throughout their professional lives.[20]

Clinical Facilitation: utilises a practice development system approach and is a technique where one person makes things easier for others. The skilled facilitator educates the nurse or midwife in the use of practice development tools. Outcomes of clinical facilitation include: participants become active, enthusiastic, self-directed learners the facilitator can become a co-learner the facilitator and participants start to genuinely collaborate as equals.[20]

Preceptorship: a relationship constructed to link experienced nurses (preceptors) with students, new graduate nurses, or new orientees (preceptees) to facilitate their orientation and integration into their new roles and responsibilities in the professional practice environment of care.[124]

Buddying: supports staff or students commencing in a new work environment. A buddy can provide encouragement and help to a new staff member, that results in greater workplace engagement.
Buddying is a form of support provided to new staff members and should ideally commence on the first day in the workplace. It is usually undertaken by a skilled and effective team member who can partner well and be an informative resource person. The right partnership between a buddy and new staff member may result in greater benefits for the organisation, because of the support provided.[20]

FACILITATED PROFESSIONAL DEVELOPMENT

Peer Review: can occur at the individual / team level or through the provision of information to a committee formed quality improvement. Nurses and midwives become active participants in monitoring and improving each other's practice and it requires them to be purposefully engaged in observing, evaluating and discussing their own work.[20]

Coaching: is a process aimed at developing specific knowledge and skills over a short time frame. Coaching usually involves a collaborative teaching, training or development process.[20]

Mentoring: is used to improve and nurture the skills, knowledge and expertise of a competent learner (mentee) by pairing them with an experienced and knowledgeable professional (mentor) of their choosing. The mentor invests and shares their time, effort, knowledge and expertise with the mentee to nurture their knowledge, skills and professional growth.[20]

PROFESSIONAL SUPERVISION

Forms part of trainee evaluation and / or the entry function into membership of a body of professionals[33] such as training programs for psychotherapists and counsellors, and psychologists and psychiatrists. While professional supervisors may utilise the techniques and styles of clinical supervision, the is a largely unnegotiable power difference that significantly impacts the relationship.

OPERATIONAL MANAGEMENT PROCESSES

Aim to ensure the goals, standards, procedures and guidelines of the organisation are being maintained and the service outcomes are being achieved[33] and include managerial supervision, disciplinary processes, performance review professional development planning and operational team meetings.

Managerial Supervision: forms part of operational management processes usually undertaken by a worker's line manager who reviews both the quality and quantity of the work (generally in relation to key performance indicators) and includes instruction, direction and evaluation.[33, 39] These processes place responsibility on the organisation and the line manager '… for ensuring that staff undertake the tasks delegated to them in a satisfactory manner'[33] and include instruction, direction, evaluation and governance.

Performance Review: involves the manager evaluating the work performance and setting goals for the following year. It is a structured process driven by organisational requirements.[38] This is best done through a collaborative and continuous process with regular meetings between worker and manager.

Operational Team Meetings: provide a regular forum for reviewing team functioning and addressing team issues as required.

CLINICAL MANAGEMENT PROCESSES

It is a managerial responsibility to ensure that robust Clinical Management Processes are in place to review clinical work and provide direction and guidance to staff to support them to deliver high- quality services and effective outcomes for service-users. Processes include case reviews, handovers, grand rounds, case presentations and clinical team meetings.[28, 29]

PERSONAL STAFF SUPPORT

Personal staff support services are provided by the employer to support the emotional, mental and general psychological wellbeing of its employees and their immediate family members.

> The aim is to provide preventive and proactive interventions for the early detection, identification and/or resolution of both work and personal problems that may adversely affect performance and wellbeing.[125]

Services provided can include Critical Incident Stress Debriefing, educative services that support self- care as well as Counselling and Psychotherapy.

Counselling and Psychotherapy: are relationship-based services provided by specifically educated health professionals that aim to assist the staff member to restore their psychological health and grow personally.[37, 40, 41]

Service-users: those who are recipients of service from nurses and midwives also known as consumers, clients and patients.

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