



Seirbhís Sláinte  
Níos Fearr  
á Forbairt

Building a  
Better Health  
Service

# CLINICAL SUPERVISION FOR NURSES WORKING IN MENTAL HEALTH SERVICES:

A Guide for Nurse Managers, Supervisors and Supervisees







Seirbhís Sláinte  
Níos Fearr  
á Forbairt

Building a  
Better Health  
Service

# **CLINICAL SUPERVISION FOR NURSES WORKING IN MENTAL HEALTH SERVICES:**

**A Guide for Nurse Managers, Supervisors and Supervisees**

**April 2019**



Office of the  
Nursing & Midwifery  
Services Director



HSE Mental Health Service





**ISBN: - 978-1-908972-16-3**

Office of the Nursing and Midwifery Services Director,  
Health Service Executive,  
Dr. Steevens' Hospital  
Dublin D08 W2A8  
Ireland  
Telephone: +353 1 6352471  
Email: [nursing.services@hse.ie](mailto:nursing.services@hse.ie)  
[www.hse.ie](http://www.hse.ie)

© **Health Service Executive**

**Recommended Citation**

O'Shea, J., Kavanagh, C., Roche, L., Roberts, L. and Connaire, S. (2019) *Clinical supervision for nurses working in mental health services: A guide for nurse managers, supervisors and supervisees*, April 2019, Office of the Nursing and Midwifery Services Director, Health Service Executive. Dublin, Ireland



## Foreword

The 2019 National Service Plan requires the Health Service Executive (HSE) to ensure that Mental Health Services are provided by highly trained and engaged staff (p56) and at over 48% of the workforce (December 2018) it is essential that mental health nurses have the knowledge and skills to provide high quality evidence based care to service users.

Recognising the potential contribution of Mental Health Nurses and in keeping with the HSE *Best Practice Guidance for Mental Health Services* (HSE, 2017a) this document emphasises the centrality of clinical supervision in maintaining a competent and skilled workforce.

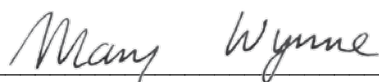
The Office of the Nursing and Midwifery Services Director (ONMSD) supports Area Directors of Mental Health Nursing to facilitate the continuing professional development of nurses working across Mental Health Services nationally, and in doing so responded to a request for additional guidance to the previously published Framework<sup>1</sup> to assist senior nurses in their services to implement clinical supervision.

It is with great pleasure that we introduce the following collection of resources to support this work:

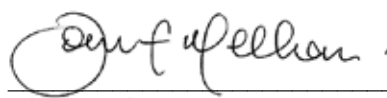
- This overall guidance document which offers clear guidance, including the process for the effective implementation of clinical supervision for nurses working in Mental Health Services in Ireland.
- A national policy from which an implementation plan can be developed in services
- A template for a Clinical Supervision Agreement
- A module descriptor for *An Introduction to Theory and Practice of Clinical Supervision*
- A FAQ document to support clinical supervision promotion within Mental Health Services
- A decision support framework for a potential breach of Code of Practice/Ethics arising during Clinical Supervision

We believe the guide supports the integration of clinical supervision into every day professional practice and provides a foundation upon which it can support continuing professional development and competence assurance into the future.

We would like to express our sincere appreciation to the members of the Steering Group who have given their time, commitment and expertise to develop and complete this important resource for mental health nurses. Specific appreciation is extended to Dr James O Shea and Ms Liz Roche (Co-chairpersons of the national group and authors) and to Ms Caroline Kavanagh, Ms Lucy Roberts and Ms Sinead Connaire (authors) for their contribution throughout its development.



**Mary Wynne**  
Nursing and Midwifery Services Director  
Assistant National Director



**John Meehan**  
Assistant National Director  
Mental Health Community Strategy &  
Head of National Office for Suicide Prevention

<sup>1</sup> Clinical Supervision Framework for Nurses Working in Mental Health Services (HSE, 2015a)



## Acknowledgements

The Office of the Nursing and Midwifery Services Director would like to acknowledge all those involved with the development of this resource, especially the National Group for Clinical Supervision in Mental Health Services (Appendix 1 for membership). Appreciation is also extended to the Peer Clinical Supervision Group, HSE Dublin North East; the Peer Group Clinical Supervision Steering Group, HSE South; and all Mental Health Services who generously shared their clinical supervision strategic plans, frameworks and other resources, all of which has been incorporated into this guidance document. Thanks also to Dr Ann Sheridan, Associate Professor, UCD School of Nursing, Midwifery & Health Systems, for peer reviewing an earlier version of this guide. Finally, special thanks are extended to Mr. Derek Milne and Mr. Ian James for giving permission to use the figure to pictorially describe the Tandem Model of Clinical Supervision.

## Disclaimer

The guidance provided in this document has been developed based on the best available evidence accessible to the National Group for Clinical Supervision in Mental Health Services. The document has been consulted with members of the Strategic Psychiatric/Mental Health Nursing Group. The aim of this document is to assist nurses within Mental Health Services to organise and participate in clinical supervision.

## Abbreviations used in this document

Abbreviation	Description
CBT	Cognitive Behavioural Therapy
CPD	Continuing Professional Development
NMBI	Nursing and Midwifery Board of Ireland
ONMSD	Office of the Nursing and Midwifery Services Director
RCNMEs	Regional Centres of Nursing and Midwifery Education
PSI	Psychosocial Interventions



# Table of Contents

<b>Chapter One: Introduction to Guidance Document</b> .....	<b>5</b>
1.1 Introduction .....	5
1.2 Background.....	6
1.3 Defining Clinical Supervision .....	6
1.4 Models of Clinical Supervision .....	7
1.4.1 Proctor’s Model .....	8
1.4.2 Cyclical Model.....	8
1.4.3 Tandem Model .....	9
1.5 Model of Clinical Supervision for Mental Health Nursing .....	9
1.6 Outline of the Clinical Supervision Guidance Document.....	10
<b>Chapter Two: Evidence Supporting Clinical Supervision</b> .....	<b>11</b>
2.1 Introduction .....	11
2.2 What the Evidence Tells Us.....	11
2.2.1 Formative Function .....	11
2.2.2 Normative Function .....	12
2.2.3 Restorative Function .....	12
2.3 Impact of Clinical Supervision on Practice .....	13
2.4 Conclusion.....	14
<b>Chapter Three: Clinical Supervision in Practice</b> .....	<b>16</b>
3.1 Introduction .....	16
3.2 Formats of Clinical Supervision.....	16
3.2.1 One-to-One Supervision .....	16
3.2.2 Group Supervision .....	17
3.2.3 Typology of Supervision Groups .....	17
3.3 What are the Main Benefits of Group Supervision .....	18
3.4 Characteristics of an Effective Supervisor .....	19
3.5 The Supervisory Relationship .....	20
3.6 The Supervision Agreement .....	21
3.7 Getting Ready for Clinical Supervision: Reflective Practice.....	23
3.7.1 Reflective Practice – what it is?.....	23
3.7.2 Why Reflection Matters .....	24
3.7.3 Models of Reflection.....	24
3.7.3.1 Kolb’s (1984) Learning Cycle .....	25
3.7.3.2 Gibbs (1988) Learning Cycle.....	25
3.7.3.3 Schön’s (1983) Model.....	26
3.8 Reflection and the role of the Supervisor:.....	27
3.8.1 Providing Feedback in Clinical Supervision .....	27
3.8.2 Clinical Supervision Evaluation .....	28
3.9 Confidentiality in Supervision.....	29
3.10 Ethical Practice in Supervision.....	29
3.11 Conclusion.....	31



<b>Chapter Four: Implementing Clinical Supervision</b> .....	<b>32</b>
4.1 Introduction .....	32
4.2 Strategic Ownership and Leadership.....	33
4.3 Definition .....	33
4.4 Policy .....	33
4.5 Education and Training.....	34
4.6 Resources and Supports.....	34
4.6.1 Organisational Supports .....	34
4.7 Supervisor Selection.....	35
4.8 Evaluation .....	35
4.9 Conclusion.....	35
<b>Chapter Five: Conclusion</b> .....	<b>36</b>
5.1 Overview .....	36
<b>Reference List</b> .....	<b>37</b>
<b>Appendices:</b> .....	<b>42</b>
Appendix I: National Group for Clinical Supervision in Mental Health Services: Membership .....	42
Appendix II: Sample Clinical Supervision Agreement .....	43
Appendix III: Decision Support Framework for Potential Breach of Codes of Practice/Ethics Arising During Clinical Supervision .....	46

## Figures

Figure 1	Cyclical Model of Supervision	9
Figure 2	Characteristics of an Effective Supervisor (One to One or Group)	19
Figure 3	The Tandem Model of Clinical Supervision	21
Figure 4	Kolb's (1984) Learning Cycle	25
Figure 5	Gibbs (1988) Learning Cycle	26
Figure 6	Five Principles of the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives	30
Figure 7	Process for Implementation of Clinical Supervision	32

## Tables

Table 1	Key Evidence Supporting the Efficacy of Clinical Supervision	14
Table 2	Proctor's Typology of Supervision in Groups	18
Table 3	Five Conditions in Supervisee Bill of Rights	21
Table 4	Components of a Clinical Supervision agreement	22
Table 5	Six Stages of Gibbs Learning Cycle	26
Table 6	CORBS Model for Feedback in Supervision	27
Table 7	Clinical Supervision and the Five Principles of the Code of Conduct and Ethics for Registered Nurses and Registered Midwives	30





# Chapter One:

## Introduction to Guidance Document

### 1.1 Introduction

Mental Health Nurses represent the largest professional discipline within the Irish Mental Health Services. Over the past decade and a half the role of nurses has developed significantly, particularly in relation to their clinical roles and responsibilities in providing timely, responsive, evidence based care. This evolution of Mental Health Nursing occurs within a complex and changing environment with consequent personal and professional demands. The report of the expert group on mental health policy, *A Vision for Change* (Government of Ireland, 2006) places firm emphasis on recovery whilst detailing a comprehensive model of Mental Health Service provision in Ireland.

Recent publications from the HSE underpin values of autonomy, trust, dignity, respect, provision of choice, and promotion of rights (HSE, 2017a; HSE, 2017b; HSE, 2018a), which, together with our profession specific values of care, compassion and commitment (DoH, 2016) are at the core of the profession of Mental Health Nursing. Clinical supervision promotes and embeds these values and recovery principles in clinical practice. The HSE *Best Practice Guidance for Mental Health Services* (HSE, 2017a) also emphasises the centrality of clinical supervision in maintaining a competent skilled workforce who can provide evidence based high quality care.

This guidance document outlines the evidence underpinning all aspects of clinical supervision; it offers a definition, model, rationale, addresses ethical considerations, and provides operational guidance for its establishment in Mental Health Services. It also supports Area Directors of Mental Health Nursing, service managers, supervisors and those receiving supervision (supervisees) in the integration of clinical supervision into every day professional practice. This practical guidance enhances and builds on the previous HSE *Clinical Supervision Framework for Nurses Working in Mental Health Services* (HSE, 2015a) and the HSE Circular 002/2015: Supervision for Health & Social Care Professionals (H&SCPs) (HSE, 2015b).



## 1.2 Background

One of the functions of the Office of the Nursing & Midwifery Services Director (ONMSD) is to support Area Directors of Mental Health Nursing to facilitate the continuing professional development (CPD) of nurses and midwives working across health services nationally. Mental Health Services have increasingly developed and evolved in a more recovery and service user focused manner, with nurses constantly developing their practice and taking on more expanded roles in the provision of care and clinical interventions. The *Vision for Psychiatric/Mental Health Nursing* (HSE, 2012) report identified the requirement for Mental Health Services to have access to a highly skilled, competent, recovery orientated workforce and recommended that clinical supervision be available for all Mental Health Nurses to support them in the delivery of a recovery focused, quality, safe Mental Health Service.

### **Recommendation 3:**

*Clinical supervision shall be made available internally to all nurses and should be availed of by all nurses to ensure recovery values and principles have been translated and maintained in clinical practice (HSE, 2012, p 28).*

The benefits of clinical supervision have been documented throughout the literature, and evidence suggests that clinical supervision offers a process of professional support and learning in which nurses are assisted in developing their practice through regular discussion with experienced and knowledgeable colleagues (Fowler, 1996, 2011). It promotes personal and professional development in a structured supportive relationship (Butterworth et al., 2008, Butterworth and Faugier, 1992). It is increasingly recommended as a means of supporting professional practice and is fundamental to safeguarding standards, developing professional expertise, and improving the delivery of quality care. Clinical supervision fits within a clinical governance framework in helping to ensure better outcomes for service users and enhancing nursing practice. It contributes to the development of a more articulate and skilled workforce which in turn impacts positively upon organisational objectives (HSE, 2015a).

## 1.3 Defining Clinical Supervision

Clinical supervision has been defined variously across the literature. A number of contemporary definitions are instructive and provide guidance for supervisors, clinicians and managers alike, in developing an understanding of the processes and consequent outcomes.

The following two definitions underpin the Clinical Supervision Framework for Nurses Working in Mental Health Services (HSE, 2015a) and together with the third definition helped inform a single definition for clinical supervision in Mental Health Nursing in Ireland.



*Clinical supervision is the term used to describe a formal process of professional support and learning which enables practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and the safety of care in complex situations. It is central to the process of learning and to the expansion of the scope of practice and should be seen as a means of encouraging self-assessment and analytic and reflective skills (Royal College of Nursing, 2003).*

*The purpose of clinical supervision is to provide a safe and confidential environment for staff to reflect and discuss their work and their personal and professional responses to their work. The focus is on supporting staff in their personal and professional development and in reflecting on their practice (Care Quality Commission, 2013).*

*Supervision is a joint endeavour in which a practitioner with the help of a supervisor, attends to their clients [and] themselves as part of their client/practitioner relationships and the wider systemic context, and by so doing improves the quality of their work, transforms their client relationships, continuously develops themselves, their practice and the wider profession (Hawkins and Shohet, 2012, p 5).*

The following definition has been agreed for Clinical Supervision in Mental Health Nursing in Ireland by the National Group:

*Clinical supervision is a professional relationship between a supervisor and a supervisee (nurse) where the supervisor facilitates the practitioner in reflecting critically upon their practice. By offering learning opportunities, support, professional guidance and oversight of the supervisee's work, clinical supervision promotes high standards of ethical practice and ensures the welfare of service users and staff alike.*

## 1.4 Models of Clinical Supervision

A broad range of clinical supervision models prevail across health and social care services. However many were originally created for Health and Social Care professions, often focusing on particular elements of their work. Therefore it is important to ensure that preferred models are appropriate for use within Mental Health Nursing and that they are compatible with the overall aims and objectives of each service's clinical supervision processes (HSE, 2017b). Three such models are relevant in this regard:

- *Proctor's Model* focuses on learning, support and accountability (Proctor, 1986; Inskipp and Proctor, 2001a);
- *Cyclical Model* offers a five stage framework for supervision (Page and Wosket, 2001, 2015);
- *The Tandem Model* (Milne, 2009) focuses on assessing learning needs, collaborative agenda-setting and the facilitation of learning by the supervisor.



### 1.4.1 Proctor's Model

Proctor's Model (Proctor, 1986; Inskipp and Proctor, 2001a) offers a robust framework within which clinical supervision can be offered. Inskipp and Proctor (2001a) identify a number of important tasks of supervision including support, learning and development and oversight. Whilst all tasks are important, any one may come to the foreground at specific times during the supervisory process. Tasks are generally negotiated between the supervisor and supervisee with this negotiation forming part of the agreement which may change over time. Three key tasks are evident within a good supervisory relationship, forming a container or safe holding space within which effective supervision can progress. The three key tasks are outlined below:

- *Restorative (support)*: This task offers emotional support for the nurse's work. Through the development of a supportive relationship, the supervisor and supervisee address emotional issues arising from practice, e.g. emotional reactions to abuse, neglect, conflict or other feelings emerging from clinical practice. It is essential that practitioners feel free to share concerns and difficulties regarding their nursing practice and subsequent emotional responses that may arise.
- *Formative (learning & development)*: This task addresses supervisee learning and professional development. Through reflective practice and self-awareness, the practitioner is enabled to explore a variety of methods in order to develop their professional skills and competence under the guidance and direction of a colleague with greater experience than themselves.
- *Normative (oversight)*: This task focuses on accountability and self-evaluation of clinical practice and considers the supervisee's roles and responsibilities. Whilst this is a shared responsibility, the clinical supervisor is ultimately responsible for ensuring that professional, legislative and policy imperatives are addressed within the supervisory space. This in turn supports the practitioner to develop skills and competencies to meet quality, safety, governance and risk management agendas (HSE, 2015a).

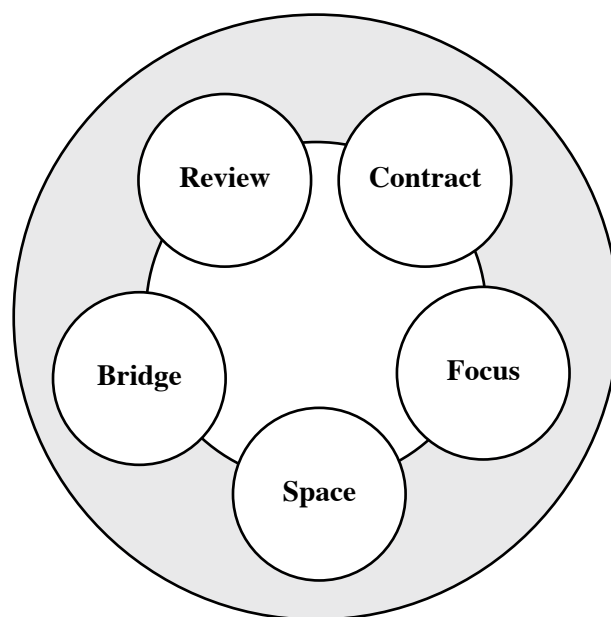
### 1.4.2 Cyclical Model

The cyclical model offers a comprehensive structured and sequenced framework for supervision. The model comprises of five stages (Figure 1) with each sub-divided into steps. The main stages include contract, focus, space, bridge and review.

- The *Contract* provides for a formal agreement between the supervisor and supervisee,
- *Focus* identifies issues which require attention,
- *Space* offers an opportunity for reflective exploration,
- *Bridge* facilitates a link between the learning in supervision and the supervisees work, and
- *Review* allows for evaluation and assessment of the supervisees work, the supervisory relationship and the contract (Page and Wosket, 2001; Wosket and Page, 2001; Page and Wosket, 2015).



Figure 1: Cyclical Model of Supervision



(Page and Wosket, 2015)

### 1.4.3 Tandem Model

Milne's (2009) model is concerned with the supervisory relationship, assessing the learning needs of the supervisee, facilitating learning and the evaluation of both the supervisee and the supervisor. This involves establishing a baseline of the supervisees' learning needs, and mutually planning how these will be addressed. Falender and Shafranske (2007) emphasise how important it is for the supervisees to identify what they "know" and also what they "don't know", so there is clarity about their learning needs from the start. Milne (2009) stresses the importance of the supervisor establishing educational goals within the learning contract, and having responsibility for facilitating the learning.

## 1.5 Model of Clinical Supervision for Mental Health Nursing

It is recommended that Proctor's Model is used as the overarching framework for the provision of clinical supervision for nurses working in Mental Health Services for the following reasons:

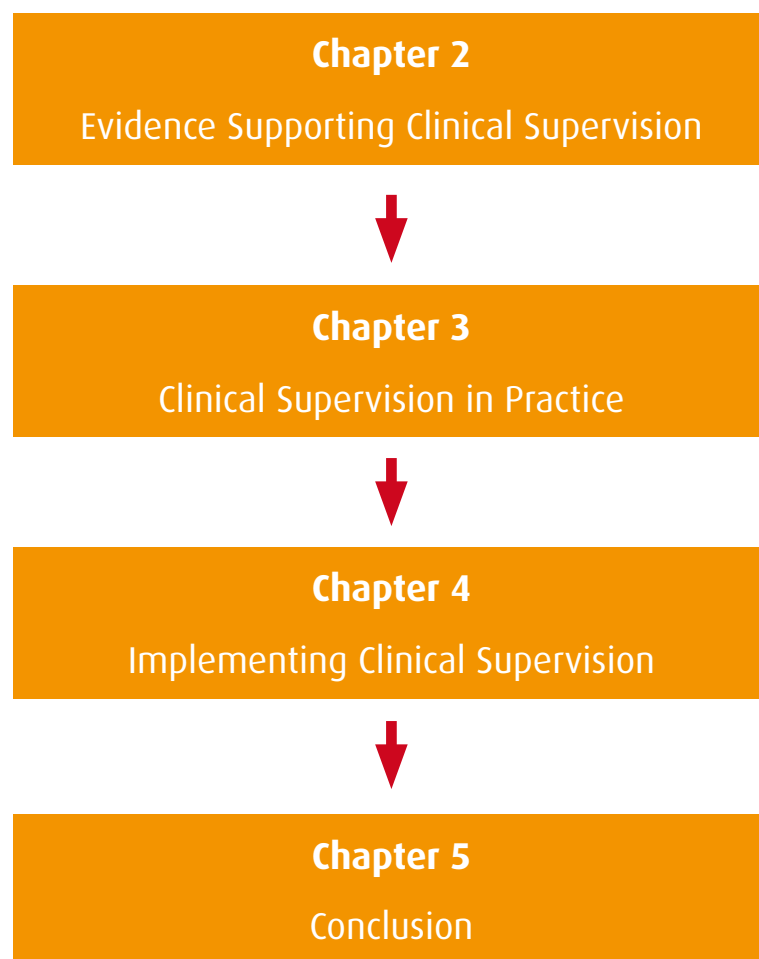
- 1) Supervisees often report challenging cases and experience the emotional burden attached to seeing clients with complex needs. In such cases the restorative function of supervision is important in giving nurses time to reflect upon their clinical practice, and helping to alleviate some of the stress associated with their clinical work (Jones, 1996; Bennett-Levy, 2006; White and Winstanley, 2010).
- 2) Through use of the normative function, the supervisor supports the supervisee to reflect on their practice in the context of relevant legislation, professional and service standards and policy. This level of accountability encourages the supervisee to advance his/her skills and capabilities in order to meet the criteria necessary for effective client-centred care and high-quality standards (HSE, 2015a).

- 3) The formative function focusing on educational aspects recognises that supervision is a mutually beneficial relationship which enhances the development of skills, knowledge and attitudes within Mental Health Nursing (Turner and Hill, 2011).
- 4) It is the model that underpins the education programme provided.

The role of the supervisor involves helping the practitioner(s) reflect, learn, change (Egan, 1994) and become increasingly reflective on their practice (Proctor, 2001). It is also recommended that supervisors draw from the cyclical model (Page and Wosket 2001; Wosket and Page, 2001; Page and Wosket, 2015) and the Tandem Model (Milne, 2009) in developing their supervisory practice.

## 1.6 Outline of the Clinical Supervision Guidance Document

This guidance document is presented as follows:



# Chapter Two:

## Evidence Supporting Clinical Supervision

### 2.1 Introduction

This chapter presents the evidence for clinical supervision with an emphasis on its efficacy within Mental Health Nursing. Given the preference for Proctor's Model as an overarching framework this chapter provides evidence on the potential of clinical supervision to achieve its *formative*, *normative* and *restorative* functions (Proctor, 1986; Inskipp and Proctor, 2001b). This is followed by an overview of the potential impact on service user outcomes.

Clinical supervision has become progressively recognised as an essential aspect of modern, effective health care delivery (Milne, 2007; Reiser and Milne, 2014). According to recent reviews in the UK, it is regarded as an important resource for Mental Health Nursing in England and Scotland (Department of Health, 2006; Scottish Executive, 2006, 2010). This recognition is mirrored in both Irish and international health national policy (HSE, 2015a; HSE, 2015b; Milne, 2007).

The benefits of clinical supervision to the supervisee are well rehearsed across the literature. They include:

- the development of professional skills and competence,
- prevention of stress and burnout,
- reduced sick leave,
- improved job satisfaction,
- feeling of being valued and improved self-esteem,
- enhanced personal and professional development, and
- promotion of safe practice.

(Rice et al., 2007; Wright, 2012; Cookson et al., 2014; Gonge and Buus, 2015)

### 2.2 What the Evidence Tells Us

#### 2.2.1 Formative Function

The *formative* or educative function of supervision focusing on learning, skills development, understanding and competence is achieved by reflecting upon and exploring one's work in supervision (Proctor, 1986; Inskipp and Proctor, 2001a). In a synthesis and thematic analysis of the literature, Pront et al., (2016) identify four 'competency' domains thought to inform the delivery of learning-focused or 'good' clinical supervision. These domains which are understood to promote learning are inter-dependent and include:

- to partner,
- to nurture,
- to engage, and
- to facilitate meaning.



The learning function of clinical supervision is seen to enhance personal and professional development and assist practitioners in meeting professional and regulatory requirements. In emphasising a commitment to lifelong learning, supervision facilitates individual practitioners to freely examine weaknesses or skills deficits in a safe, supportive environment (Rice et al., 2007). According to Cookson et al., (2014), it offers practitioners a structured opportunity to reflect upon their practice which is supportive of developing clinical knowledge and competence.

### 2.2.2 Normative Function

The *normative* or oversight function, often viewed within a gate-keeping or quality-control domain, supports nurses in ensuring that professional standards and organisational roles are achieved (Proctor, 1986; Inskipp and Proctor, 2001a). In a systematic review and meta-analysis within broader medical settings Snowdon et al. (2016) conclude that clinical supervision is associated with safer medical interventions. Rice et al. (2007) connect clinical supervision with a governance agenda that supports accountability; assures the public that standards are achieved; detects and learns from adverse events; maintains and disseminates good practice; and ensures continuous improvement in clinical care. Within this context, clinical supervision is seen to encourage safe autonomous practice that reflects person-centred care and reduces pre-occupation with a blame culture, thus encouraging openness through a supportive reflective process. Managers can also be assured that through clinical supervision they have processes in place to ensure that the code of professional conduct, guidelines and standards are adhered to and that the principles of clinical governance are upheld.

Supervision can improve practice standards leading to increased safe care delivery which results in less complaints and reduced litigation. It can also offer a safeguard for managers by supporting practitioners to review and continually reassess their professional actions (Rice et al., 2007).

### 2.2.3 Restorative Function

The *restorative* or support function pays attention to the emotional needs of supervisees in light of the impact that their work may have on their mental health and wellbeing (Proctor, 1986; Inskipp and Proctor, 2001a). Within this domain MacColloch and Shattell (2009) suggest that the burden of bearing personal, clinical, and professional responsibility for service users is a substantial one which may weigh heavily on Mental Health Nurses. In their analysis clinical supervision should play a role in “...*fostering hope in the midst of client despair, hardship, and serious mental illness...*” (p 590). MacLaren et al. (2016) demonstrate that a supervision culture is associated with reduced levels of burnout and can enable nurses to contain and embrace difficult emotions outside of formal sessions. They suggest that:

*Where a safe, supportive micro-culture is successfully created, otherwise suppressed and unexamined emotional processes can be explored, enabling nurses' development as emotionally intelligent, critically self-aware practitioners (p 2431).*





The findings of a study conducted by Edwards et al. (2006), aimed at establishing the degree to which clinical supervision might influence levels of burnout in community Mental Health Nurses, suggest that “...if clinical supervision is effective then ...nurses report lower levels of burnout” (p 1007). This point is echoed by Cookson et al. (2014) who concur that supervision results in reduced stress, burnout and sickness absence and alleviates the negative consequences of working with challenging behaviours.

MacCulloch and Shattell (2009) also commenting upon this restorative function conceptualise a

*deeply respectful, empathic relationship [with] the potential for practitioners to be nourished, affirmed, challenged, and refreshed (p 590).*

In their analysis nurses can:

*...experience a safe trusting space in which to reflect deeply on the impact of their practice on the client and of the inner processes that their work is triggering in themselves (p 590).*

Thus the supervisory space offers a setting in which the practitioner can re-connect with, and sustain a sense of meaning and purpose in their challenging work environments and the associated powerful emotional responses those engagements can elicit (MacCulloch and Shattell, 2009). Similarly Rice et al. (2007) propose that as a result of clinical supervision, practitioners experience feeling valued and their self-esteem and professional confidence is increased. In their view this is particularly evident where their clinical opinion is sought by other professionals. Gonge and Buus (2011) draw a number of these threads together reporting that participation in clinical supervision is significantly associated with benefits in terms of increased job satisfaction, vitality and rational coping as well as reductions in stress, emotional exhaustion, and depersonalisation.

### **2.3 Impact of Clinical Supervision on Practice**

Clinical supervision is also demonstrated to have beneficial effects for service users and organisations. Cleary and Freeman (2006) commenting on the value of clinical supervision note that “... the benefits to consumers of educated, valued, and supported staff are undisputed and it is vital that ways of achieving this continue to be developed” (p 997). White and Winstanley (2010) in an RCT claim to have made “...incremental headway toward establishing an evidence base for some of the claims made about [Clinical Supervision]” (p 164). They highlight the importance of the service and managerial culture on the outcome of implementation efforts. They corroborate evidence that staff value and benefit from clinical supervision. Further key evidence supporting the efficacy of clinical supervision in Mental Health Nursing is summarised in Table 1.



**Table 1: Key Evidence Supporting the Efficacy of Clinical Supervision**

Alleyne and Jumaa (2007)	Clinical supervision is associated with improved care to service users.
Butterworth et al. (2008)	Employees who are supported and are allowed time to reflect and develop will make a significant contribution to patient wellbeing and safety (p 270).
Gonge and Buus, (2015)	Clinical supervision has positive effects on staff and clinical areas already engaged in the supervisory process, however services without established supervision practices “...may require more comprehensive interventions targeting individual and organizational barriers to clinical supervision” (p 909).
Bradshaw, Butterworth and Mairs (2007)	Service users seen by students receiving clinical supervision “...showed significantly greater reductions in positive psychotic symptoms and total symptoms compared with those seen by students in the control group...” (p 4)
White and Roche (2006)	Clinical supervision offers a practical antidote to address both the causes and the effects of sub-optimal service provision in Australian Mental Health Services
Buus et Al. (2011)	Formalised supervision was the only forum for reflection that could solve the most difficult situations (p 95).

## 2.4 Conclusion

Despite this overall positive appraisal, the challenges of evaluating clinical supervision within a complex mental health system are well acknowledged. It is not possible to control for all potential variables within research and claims that improvements in service user outcomes are specifically attributable to clinical supervision are limited (Cleary et al., 2010; Lynch et al., 2008a). However, research and practice are evolving in a manner that has the potential to offer increased clarity (Watkins, 2011).

Taking a broader perspective on supervision’s key functions within Proctor’s Model (Proctor, 1986; Inskipp and Proctor, 2001a) and the breadth of potential benefits to service users, the value of providing clinical supervision outweighs both costs of provision and the challenges associated with its emerging evidence base. In reviewing the evidence Brunero and Stein-Parbury (2008) reinforce this point concluding that:



*There is research evidence to suggest that [clinical supervision] provides peer support and stress relief for nurses (restorative function) as well a means of promoting professional accountability (normative function) and skill and knowledge development (formative function)(p 86).*

It is therefore important to maximise the potential benefits to service users and staff by developing comprehensive implementation strategies and continuing to apply robust research methodologies which review and critique the content, processes and outcomes of clinical supervision. The use of a co-evaluation approach (HSE, 2018) will support the evaluation process and ensure its impact is evaluated within the context of a recovery model of care.

It is also essential that Mental Health Nurses actively engage in research, audit and publication of their experiences of clinical supervision in order to create further clarity on the evidence base for its utilisation and implementation in Ireland.



# Chapter Three:

## Clinical Supervision in Practice

### 3.1 Introduction

This chapter provides practical guidance on clinical supervision in practice including the formats of clinical supervision, the supervisory relationship, the clinical supervision agreement and effective characteristics of a clinical supervisor. This chapter explores the concept of reflective practice and learning within clinical supervision for Mental Health Nursing and outlines a framework for giving feedback and carrying out evaluation within the context of a supervisory relationship. Lastly it explores confidentiality issues and the ethical dimensions for Mental Health Nurses within the clinical supervision process.

### 3.2 Formats of Clinical Supervision

In order for supervision to be effective, it is necessary to take into account both the needs of the individuals and the requirements and constraints of the organisation when considering the format to be offered. The clinical supervision format chosen by an individual organisation requires consideration of the different work contexts as well as the professional development needs and expectations of staff. Supervision can be provided on a one to one basis or in groups, which may be facilitated or peer-led.

Different formats or ways of delivering clinical supervision may include the following:

- One-to-one supervision between a supervisor and supervisee,
- Group supervision in which two or more practitioners discuss their work with a supervisor,
- Peer supervision, where practitioners of the same grade discuss their work with each other (one to one or group)
- Co-supervision where two practitioners provide one-to-one supervision to each other.
- A combination of the above.

It is recommended that clinical supervision be provided by trained experienced supervisors where supervision is being offered to inexperienced staff. It is also recommended that the supervisor, for all of the above formats have undertaken or undergo appropriate training in clinical supervision facilitation.

#### 3.2.1 One-to-One Supervision

One-to-one supervision may be a preferred model to engage with and is widely used to provide a safe place for reflecting on complex practice as it provides individual support in exploring practice and making decisions. Mental Health Nurses are encouraged to read Section 3.7 of this guidance document in relation to reflection and its importance in clinical supervision.



### 3.2.1.1 What are the Main Benefits of One-to-One Supervision?

Bond and Holland (2010) highlight the benefits of one to one clinical supervision as:

- Practical and easy to arrange mutually convenient times,
- More appropriate individual amount of time for reflection,
- Preferable for beginners, as less complex than group,
- Self-disclosure can be less frightening than group,
- More continuity, the same supervisor each time,
- Preferred by individuals who may have had a bad experience in learning groups,
- Greater sense of individual being listened to and cared for by the organisation,
- The supervision relationship and working alliance can develop more deeply more quickly.

The three day *Introduction to Theory and Practice of Clinical Supervision* education programme, developed as part of this overall clinical supervision resource pack encompasses both theory and practice of one to one supervision.

### 3.2.2 Group Supervision

Services may choose a group supervision format in order to maximise the utilisation of resources and tap into the collective expertise that already exists within mental health nursing. The main goal of group supervision is to enable supervisees to reflect on their work. By combining knowledge, skills and experience, the aim of the clinical supervision session is to improve the skills and competencies of both the individuals and the group. Participants contribute to, listen to and challenge different perspectives regarding real workplace experiences. The goal of group supervision is to solve problems, plan work, set priorities, learn from others, and/or make decisions. This process facilitates individuals to reflect on decision making and to consider new methods of working while promoting both personal change and culture change within the workplace.

### 3.2.3 Typology of Supervision Groups

Proctor (2008) outlines a framework for identifying different types of supervision in groups (Table 2). This approach is useful to:

- Identify roles and responsibilities in the group,
- Clarifying the agreement between the supervisor, supervisee and the organisation,
- Create ground rules or a working arrangement for the group and its participants.



Table 2: Proctor's Typology of Supervision in Groups

<b>Type 1: Authoritative group</b> (supervision <i>in</i> group)	<ul style="list-style-type: none"> <li>• Supervisor supervises each supervisee in turn</li> <li>• Supervisor manages group</li> <li>• Supervisees are primarily observers and learners</li> </ul>
<b>Type 2: Participative group</b> (supervision <i>with</i> group)	<ul style="list-style-type: none"> <li>• Supervisor supervises and manages the group</li> <li>• Supervisor takes primary responsibility for supervision</li> <li>• Supervisor teaches and inducts group to engage as co-supervisors and take increasing responsibility in the supervisory process</li> </ul>
<b>Type 3: Co-operative group</b> (supervision <i>by</i> group)	<ul style="list-style-type: none"> <li>• Supervisor acts as group facilitator and monitor</li> <li>• Supervisees co-supervise and develop as a supervising system</li> </ul>
<b>Type 4: Peer group</b>	<ul style="list-style-type: none"> <li>• Group members take shared responsibility for supervising and being supervised</li> <li>• No permanent supervisor is present and leadership rotates</li> </ul>

Proctor (2008) describes the participative group as one where the supervisor is responsible for supervising and managing the process. The supervisor takes prime responsibility for supervising and managing the process and also inducting the group to engage as co-supervisors. The participative group is a suitable mode for the provision of clinical supervision within Mental Health Nursing in Ireland, and supervision may move towards co-operative or peer group formats as supervisors and supervisees become more skilled and confident in the supervision process.

### 3.3 What are the Main Benefits of Group Supervision?

Group supervision can create a rich diverse learning forum which enhances problem solving by drawing on the expertise of a diverse group of people. It enables learning from the different backgrounds, cultures and experiences of individuals who may provide different perspectives on situations. Group supervision presents an opportunity to address the concerns and issues of individuals and also an opportunity to develop teams.

Bernard and Goodyear (2014) and Hawkins and Shohet (2012) identify the benefits of group supervision:

- Economies of time, cost and expertise,
- Opportunities for vicarious learning,
- Breadth of work experience/exposure,
- Quantity and diversity of feedback,
- Emergence of more comprehensive picture of supervisees,
- Normalising of supervisee's experience,
- Learning about group process,
- Receive energy and support from others,
- Organisational learning becomes more possible,



- Exposes supervisee's 'blind spots', 'deaf spots' and 'dumb spots',
- Group members act as a witness to breakthrough and commitment.

The *Introduction to Theory and Practice in Clinical Supervision* education programme encompasses both the theory and practice of group supervision. Recommended additional reading includes publications and books by Proctor and/or Hawkins and Shohet, and Bernard and Goodyear.

### 3.4 Characteristics of an Effective Supervisor

An effective supervisor is one who is able to provide the emotional and practical support that the supervisees require to promote growth, development and learning while ensuring that standards of care are maintained for people who use services (Munsen, 2002). Supervisors who feel confident in their own knowledge base and have sound clinical skills are more likely to facilitate discussions which challenge their supervisees (Bernard and Goodyear, 2004). Additionally, the capacity of supervisors to feel confident enough in their role to admit the limits of their knowledge, including when to secure additional input for the supervisee, is crucial. A number of supervisor characteristics are noteworthy in this context and are presented in Figure 2.

Figure 2: Characteristics of an Effective Supervisor (One-to-One or Group)



(Edwards et al., 2005; Martin et al., 2014)



### 3.5 The Supervisory Relationship

The supervision alliance creates a foundation for effective clinical supervision. The supervisor and supervisee's relationship is the key to successful supervision (Pritchard, 1995). Munsen (2002) identifies trust as central to the relationship. Falender and Shafranske (2014) acknowledge that if supervisors establish a relationship and perform with competence, integrity and ethical adherence, supervisees are more likely to openly discuss challenges they encounter while undertaking their role. The supervisor serves as a role model for the supervisee, fulfils the highest duty of protecting the public and is a gatekeeper for the profession, ensuring that supervisees meet competence standards. Page and Woskett (2001; 2015) highlight the primacy of the relationship over other dimensions of the supervisory process. Sharing the principles of all good human relationships the supervisory engagement requires collaboration, empathy, a non-judgemental approach, affirmation and a commitment to experimentation and exploration. Good supervision is said to be about the relationship rather than the technique (Ellis, 2010) and is described as a collaborative interpersonal process (Falender and Shafranske, 2004). Bordin (1983) believes that an emotional bond is necessary for productive supervision. In their analysis, relationships are concerned with the attitudes and feelings that supervisors and supervisees have towards each other.

The ability to establish and maintain the supervision relationship is a core requirement of the supervisor. Davys and Bedoe (2010) collectively provide the context for open sharing where supervisors and supervisees can enter a creative space where both can be transformed.

There are four fundamental qualities of a good supervisory relationship:

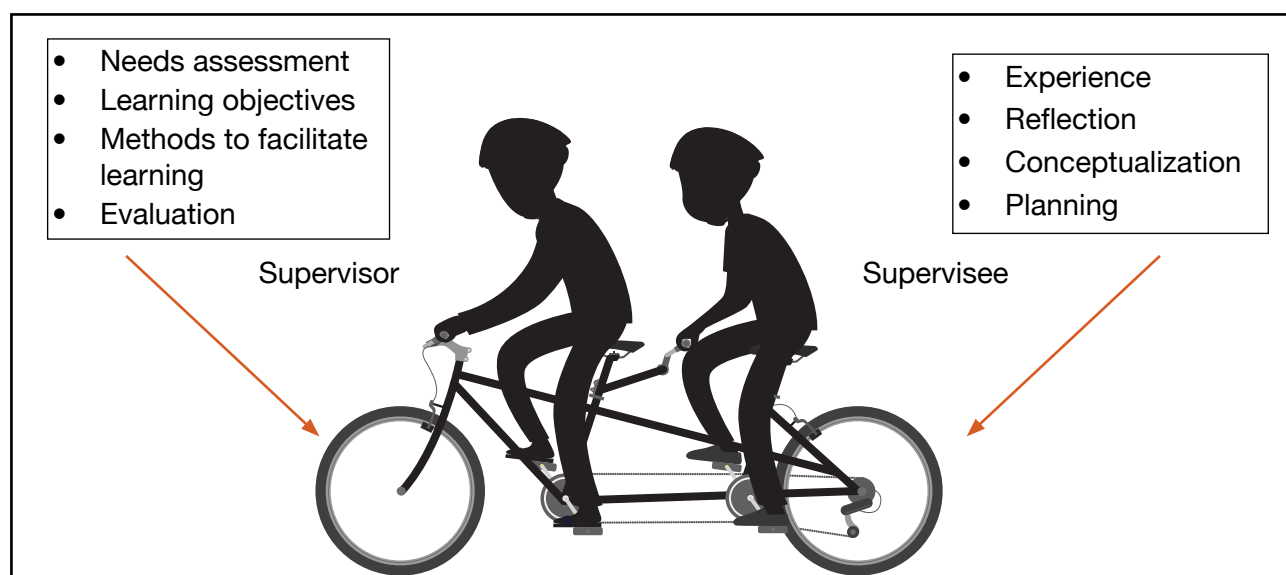
- authenticity,
- respect,
- positive regard, and
- a mutual openness to learning.

Milne and James (2005) 'Tandem Model' utilising the metaphor of a tandem bicycle, explain how learning and development occur in supervision. The leader (the supervisor) steers the tandem and the supervisee follows. The front wheel (under the control of the supervisor) represents the interrelated steps of needs assessment, agreeing learning objectives, the use of methods to facilitate learning and evaluation. The rear wheel (steered by the supervisee) represents the experiential learning cycle (Kolb, 1984) with its four modes of learning: experience, reflection, conceptualisation and planning. According to the model it is the role of the supervisor to ensure that the supervisee moves around the learning cycle appropriately. The learning cycles are linked together by the frame, with the supervisor providing 'scaffolding' for the learning for the supervisee. The gears are seen as the 'mechanisms of change' or 'processes whereby learning takes place' as outlined in Figure 3.





Figure 3: The Tandem Model of Clinical Supervision



Milne, D. and James, I. (2005)

### 3.6 The Supervision Agreement

Using a supervision agreement has been identified as a key component of an effective supervision process (Gaitskell and Morley, 2008). Bernard and Goodyear (2014) believe that collaboratively designing the learning agreement can be beneficial to the supervisory relationship and can be viewed as an educational exercise in itself. By forming an agreement at the beginning of the supervisory relationship the boundaries, ground rules, goals, process issues and the identification of learning needs can be established (Van Ooijen, 2000; Gaitskell and Morley, 2008). Using an agreement helps all parties to be aware of their expectations, to examine respective hopes and fears for the relationship, and to negotiate supervision needs (Martin et al., 2014).

Bernard and Goodyear (2014) note that contractual agreements should clearly identify the responsibilities of all parties and position the supervisee at the centre with their rights playing a fundamental role. Referring to the work of Munsen (2002) they articulate a bill of rights for supervisees which include five key conditions which are outlined in Table 3.

Table 3: Five Conditions in Supervisee Bill of Rights

1.	Consistent supervision at regular intervals
2.	Growth orientated supervision that respects supervisee's personal privacy
3.	Technically sound and theoretically grounded supervision
4.	Clearly stated assessment criteria that are articulated in advance and based upon actual observation of performance
5.	Supervision provided by a supervisor who has training in supervision and is skilled in clinical practice



In clearly articulating the key elements of the supervisory agreement and prioritising the supervisee rights, Bernard and Goodyear's insights point us to the need for respect and integrity at the heart of the supervisory arrangement (Bernard and Goodyear, 2014; Hawkins and Shoheit, 2012). Carroll and Gilbert (2011) propose a practical framework suggesting that the clinical supervision agreements should revolve around the following:

- (i) *Exchange* – what we will do for each other
- (ii) *Reciprocity* – the need for a two way agreement
- (iii) *Choice* – the importance of freely entering the arrangement
- (iv) *Predictability* – know what will happen in supervision
- (v) *Future* – agreeing what we 'will' do
- (vi) *Responsibility* – agreeing 'who' is accountable for 'what'
- (vii) *Regular review* – ensuring a regular review of the agreement

The principal components of a clinical supervision agreement are outlined in Table 4 below:

**Table 4: Components of a Clinical Supervision agreement**

<b>Supervisee Details</b>	Name of Supervisee
<b>Supervisor Details</b>	Name of Supervisor
<b>Functions of Supervision</b>	Discussion of functions of supervision including learning, quality oversight of practice and rejuvenation (formative, normative and restorative)
<b>Confidentiality</b>	(i) Confidentiality and its limits; (ii) exceptions to confidentiality; (iii) organisational policies on confidentiality/Children First and other relevant legislation
<b>Term of Supervision</b>	Duration of supervision agreement, review dates and ending of agreement
<b>Identified Learning Needs</b>	Clarity on learning needs related to (i) training, (ii) pre-registration/ internship requirements, (iii) pre-accreditation (nurse therapist grades), (iv) requirement for ongoing accreditation (nurse therapist grades), (v) professional development or (vi) service requirement
<b>Practical Issues</b>	Duration of sessions, timing, frequency, cancellations, non-attendance, fees (if external), venue and contacts for emergencies
<b>Expectations</b>	Discussion of any previous experience of supervision, expectations of supervisor, supervisee, organisation, NMBI, other professional bodies or other stakeholders
<b>Relationship</b>	Discussion of the supervisory relationship – roles and responsibilities of supervisor and supervisee
<b>Accountability</b>	Discussion on NMBI (2015) <i>Scope of Nursing and Midwifery Practice Framework</i> , NMBI (2014) <i>Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives</i> legal requirements, other professional bodies, employing organisation, links to line manager and recording of information
<b>Boundaries</b>	Discussion of boundaries related to any (i) therapeutic, training or professional development aspects of supervision, (ii) handling social or professional contact outside of supervision.
<b>Roles and Responsibilities</b>	Roles and responsibilities of supervisor, supervisee and the organisation
<b>Evaluation</b>	Evaluation in supervision and completion of reports

It is recommended that clinical supervision agreements are developed for all formats of clinical supervision (one-to-one or group). A template for the development of the Clinical Supervision Agreement is available in Appendix II. It incorporates all the components of the above table using the framework of Proctor's model.

### 3.7 Getting Ready for Clinical Supervision: Reflective Practice

Being able to reflect on one's clinical practice and its impact on "self" is central to effective clinical supervision. The Scope of Nursing and Midwifery Practice Framework (NMBI, 2015) encourages nurses and midwives to critically examine the scope of their practice and advocates reflective practice to improve learning and the provision of safe, quality care. Reflective practice is described as the ability to reflect upon one's actions so as to engage in a process of continuous learning (Schon, 1983) and involves 'reviewing an experience in order to describe, analyse, evaluate and so inform learning about practice' (Reid, 1993).

#### 3.7.1 Reflective Practice – what it is?

Benner (1984) introduced the idea that expert nurses develop skills over time through a solid educational base as well as a multitude of clinical experiences. Benner proposes five stages of nursing experience including: Novice, Advanced Beginner, Competent, Proficient and Expert. Bennett-Levy (2006) outlines a model of skills development incorporating three principal systems including Declarative, Procedural and Reflective learning (DPR). The declarative system is concerned with 'knowing' that something is the case; typically declarative knowledge is learned didactically through lectures or observational learning. Procedural knowledge is the 'how to' and 'when to' apply the skills in practice. Skills are believed to become automatic when there is a combination of didactic learning, modelling through supervision, ongoing practice and feedback. Reflective knowledge is achieved by reflecting on both declarative and procedural knowledge in order to promote skills development (ibid).

Reflective practice generally refers to a practitioner's ability to observe their thoughts, behaviour, feelings, skills, attitudes and professional conduct from an objective viewpoint. Boyd and Fales (1983) suggest 'reflective learning is the process of internally examining and exploring an issue of concern, triggered by an experience, which creates and clarifies meaning in terms of self, and which results in a changed conceptual perspective'. Driscoll (2007) suggests that supported reflective learning is in itself the very essence of the clinical supervision encounter. Supervision provides a secured place to reflect one's performance in one's own work (Hawkins and Shohet, 2012).



### 3.7.2 Why Reflection Matters

The rationale given for locating reflection at the core of clinical supervision is multiple and varied but should include the following:

- Clinical supervision enables the supervisee to focus on a particular aspect of their clinical practice in a way that they would not normally do.
- It is characterized by reflection on previous action and its implications for future action. A clinical supervisor will often challenge the supervisee to think outside of their current ways of working.
- The clinical supervisor will offer support and advice that encourages the supervisee to learn alternative ways of working and the development of specific skills.
- The clinical supervisor will be interested in the quality of the supervisee's work practices and will offer constructive feedback.

Being reflective allows a practitioner to be exposed to a variety of perspectives, which in turn can lead to different ways of understanding situations or completing a course of action. The quest for self-awareness and self-understanding is a major component of effective reflective practice. Mental Health Nurses need to be aware of their skills, knowledge and performance as professionals and also be mindful of personal factors that may influence or impede their ability to provide an effective service. Reflective practice offers a more thorough understanding of ethical dilemmas in their practice and promotes new ways of thinking (Thompson and Thompson, 2008). In so doing it becomes an integral component of clinical supervision serving to activate the educative function. Carroll and Gilbert (2011) suggest that reflective practice:

- is a key component of learning,
- helps to prevent us from falling into "mindlessness",
- involves holding our experiences up to the light and pondering their meaning,
- is our human way of making meaning,
- is the process that turns information and knowledge into wisdom,
- becomes a way of helping us make sense of our experiences and gives us choice as to how we will respond through reflection, reflexivity and critical thinking,
- is a way of helping us to look at our work and see it from different perspectives,
- offers a method through which we learn is the "*...discipline of wondering about...what if..*"

### 3.7.3 Models of Reflection

This section recommends the following models of reflection:

- Kolb's model: Kolb is the founder of learning theory and essential to learning and supervision.
- Gibb's reflective model is utilised by student nurses and introduces the concept of reflecting on clinical practice. Most students have reflective time factored in to their diary,



particularly on clinical placements. It provides a structure for nurses to follow and helps to facilitate learning.

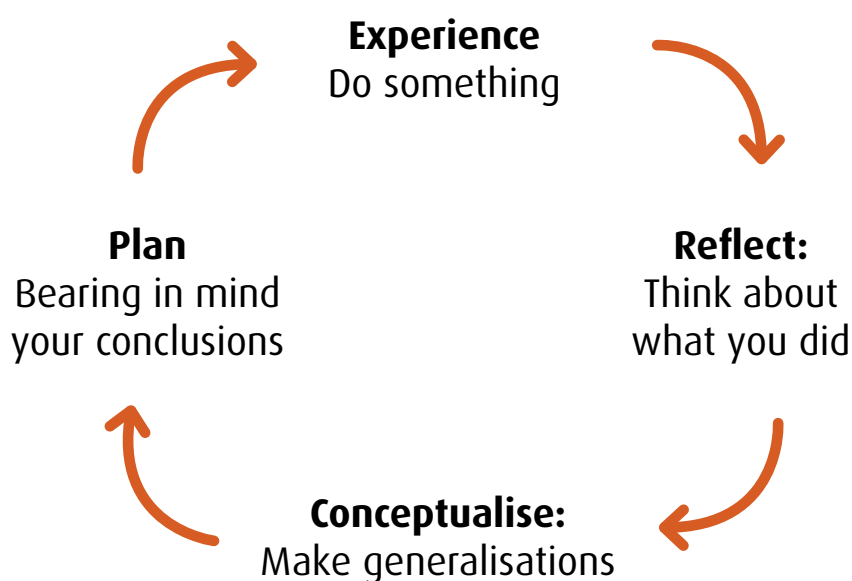
- Schon's model demonstrates Benner's work, in that novice practitioners tend to reflect on action, thereby looking back at an event and learning from it, whereas an expert practitioner is able to reflect in action (whilst on their feet) to adapt their nursing approach to deal with a particular clinical situation which takes a high level of skill and competencies.

Milne's work places emphasis on both the supervisee and supervisor's learning and development (it links to Kolb) and also emphasises that whether the supervisee is a novice or expert, mutual learning should always continue to take place with learning a lifelong/career-long pursuit.

### 3.7.3.1 Kolb's (1984) Learning Cycle

Kolb's (1984) Learning Cycle is a well-known theory which argues that nurses learn from life experiences, even on an everyday basis. It also treats reflection as an integral part of such learning. According to Kolb (1984), the process of learning follows a pattern or cycle consisting of four stages, one of which involves what Kolb refers to as 'reflective observation'. The stages are illustrated and summarised below in Figure 4.

Figure 4: Kolb's (1984) Learning Cycle



### 3.7.3.2 Gibbs (1988) Learning Cycle

Gibbs (1988) Learning Cycle is widely utilised within the nursing profession and incorporates six stages of reflection including description, identification of emerging feelings, evaluation, analysis, reaching conclusions and developing an action plan. Each stage supports the reflective practitioner in making sense of experiences and examining their practice. Essentially it encourages practitioners to think systematically about the phases of an experience. Gibbs (1988) Learning Cycle is outlined in Figure 5.



Figure 5: Gibbs (1988) Learning Cycle

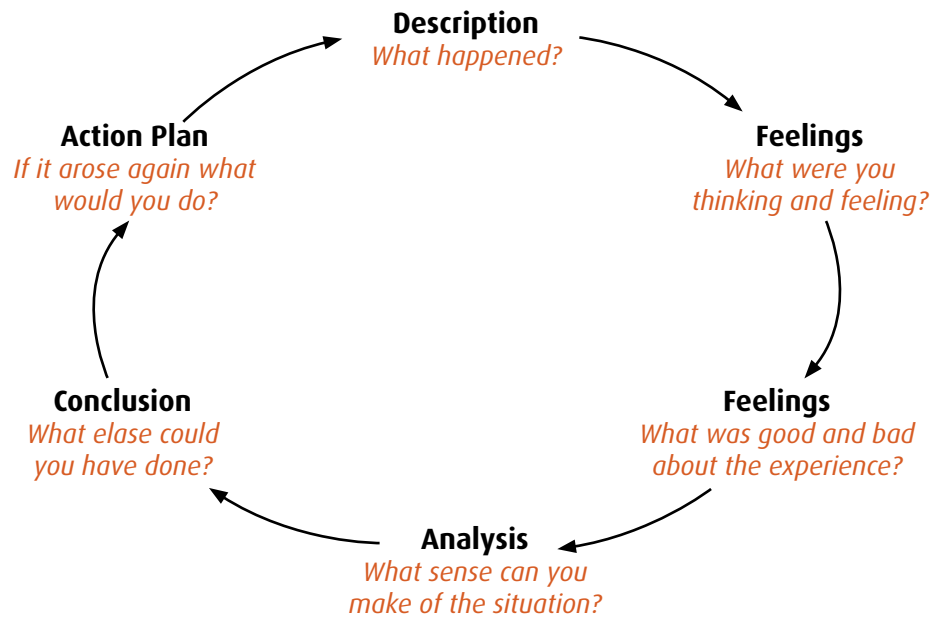


Table 5: Six Stages of Gibbs Learning Cycle

<b>Description</b>	What happened? Don't make judgements yet or try to draw conclusions; simply describe.
<b>Feelings</b>	What were your reactions, thoughts and feelings?
<b>Evaluation</b>	What was good or bad about the experience? Make value judgements
<b>Analysis</b>	What sense can you make of the situation? What was really going on? Were different people's experiences similar or different in important ways?
<b>Conclusions</b>	What can be concluded, in a general sense, from these experiences and the analyses you have undertaken? What can be concluded about your own specific, unique, personal situation or way of working?
<b>Action plans</b>	What are you going to do differently in this type of situation next time?

### 3.7.3.3 Schön's (1983) Model

Schön's (1983) concept of *reflection-in-action* and *reflection-on-action* distinguishes between reflecting on an incident whilst it is occurring and reflecting on clinical practice after an event. Reflection-in-action is a useful tool to use where a nurse is required to respond to an event in real-time. In contrast reflection-on-action involves reflecting on how practice can be developed (changed) after the event by looking back to discover what has been learned and what the nurse may need to change in the future.



The process of reflection provides a means of conceptualising and planning for future learning and development (Bennett-Levy, 2006). It is important to ensure that clinical supervision is developmentally appropriate to the Mental Health Nurses level of training and expertise (Stoltenberg et al., 1998). The supervisor should take into account the supervisee's progress and review it on an ongoing basis, and be cognisant of providing scaffolding for the learning of the supervisees depending on their experience and learning needs (Van de Pol et al., 2010).

### 3.8 Reflection and the Role of the Supervisor:

#### 3.8.1 Providing Feedback in Clinical Supervision

The supervisor's role involves giving and receiving feedback (both evaluative and non evaluative) and seeks to address professional accountability and practice issues (Proctor, 2011). Carroll and Gilbert (2011) propose that one of the most difficult skills to acquire is the ability to give feedback within supervision. Feedback should be specific, factual, concrete and behavioural in order that the supervisee discovers what is working well and what they may need to do differently (Davys and Beddoe, 2010). Hawkins and Shohet (2012) acknowledge the challenges inherent to giving and receiving feedback and offer the CORBS model (Table 6) to provide guidance on how to offer feedback.

Table 6: **CORBS** Model for Feedback in Supervision

<b>Clear</b>	<ul style="list-style-type: none"> <li>• Be clear about what feedback is to be given</li> <li>• Vagueness and faltering approach increase anxiety and lead to misunderstanding</li> </ul>
<b>Owned</b>	<ul style="list-style-type: none"> <li>• Feedback is presented as a 'perception' and not the ultimate truth</li> <li>• It says as much about you as it does about the other person</li> <li>• E.g. <i>"I find you"</i> rather than <i>"You are"</i></li> </ul>
<b>Regular</b>	<ul style="list-style-type: none"> <li>• Feedback should be given regularly so that any possible grievances don't build up</li> <li>• Feedback should be given as close to the event as possible</li> </ul>
<b>Balanced</b>	<ul style="list-style-type: none"> <li>• Negative and positive feedback should be balanced</li> <li>• You don't have to give positive feedback with every piece of critical feedback, however it should be balanced over time</li> </ul>
<b>Specific</b>	<ul style="list-style-type: none"> <li>• Feedback should be specific – it is difficult to learn from generalised feedback</li> </ul>

(Hawkins and Shohet, 2012, p 159-160)



### 3.8.2 Clinical Supervision Evaluation

Bernard and Goodyear (2014) believe that the evaluation process serves a '*gate-keeping*' function within supervision; the supervisor has a responsibility to the profession, to service users and to supervisees to ensure safe and effective practice. They divide the evaluation task into both *formative* and *summative* functions:

- Formative is the ongoing evaluation process of skills acquisition, and development and professional growth.
- Summative function is more of an assessment of how the student/supervisee performs overall. Summative evaluations are more likely to be required for students on placement in conjunction with their preceptor's report, and also to Mental Health Nurses who are undertaking post graduate studies in a specialist role such as Cognitive Behavioural Therapy (CBT) or Psychosocial Interventions (PSI) where formal assessment of competencies is required.

Evaluation has a key role to play in the learning and development of Mental Health Nurses, and connects seamlessly with Proctor's (1986) normative and formative functions of clinical supervision. Milne's (2009) Tandem model suggests that the evaluation process should involve ongoing judgment of the professional practice of both the supervisor and the supervisee in order to maximise learning. By way of supporting a mutual learning environment, Carroll and Gilbert (2011) advocate that evaluation should be a 'two way process' where the supervisor and supervisee offer each other evaluative feedback.

Bernard and Goodyear (2014) identify six elements of evaluation which interact throughout the supervision experience which are outlined below:

1. Negotiating a supervision evaluation contract,
2. Choosing evaluation methods and supervision interventions,
3. Choosing evaluation instruments,
4. Communicating formative feedback,
5. Encouraging self – assessment,
6. Conducting formal summative evaluation.

In summary, evaluation and assessment of competence forms a cornerstone of the supervisory process with supervisors being required to attend to the normative function which ensures quality and accountability in practice for Mental Health Nurses. However, this process affords the supervisor and supervisee with broader opportunities for evaluation of the supervisor, supervisee, the work and the supervisory process in a collaborative reciprocal process of reflection and self-examination.





### 3.9 Confidentiality in Supervision

Clinical supervision sessions are based on a trusting relationship between supervisor and supervisee and both parties have the right to expect the content of the sessions will remain confidential. Therefore professional and clinical issues discussed are confidential and must not be discussed outside the supervision sessions.

The exceptions to this should be outlined in the clinical supervision agreement and may include circumstances where a supervisee discloses information which is deemed to compromise the safety of a service user, colleague or the supervisee themselves. This is in accordance with NMBI Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI 2014) – Principle 5, Standard: 4:

*‘If the safety of wellbeing of a patient or colleague is affected or put at risk by another colleagues actions, omissions or incompetence, you must first take appropriate action to protect people from harm. You should then immediately report the conduct to your manager, employer and if necessary the relevant regulatory body’.*

Appendix III provides a decision support framework for a potential breach of Code of Practice/Ethics arising during clinical supervision.

### 3.10 Ethical Practice in Supervision

The Nursing and Midwifery Board of Ireland (2014) *Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives* offers a clear framework for ethical practice within a Mental Health Nursing context and is applicable to the practice of clinical supervision. The HSE North East, Nursing and Midwifery Peer Group Clinical Supervision Strategic Plan (HSE, 2017b) integrate the provision of supervision with the five principles of the Code and are outlined in Figure 6.



Figure 6: Five Principles of the Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI 2014)

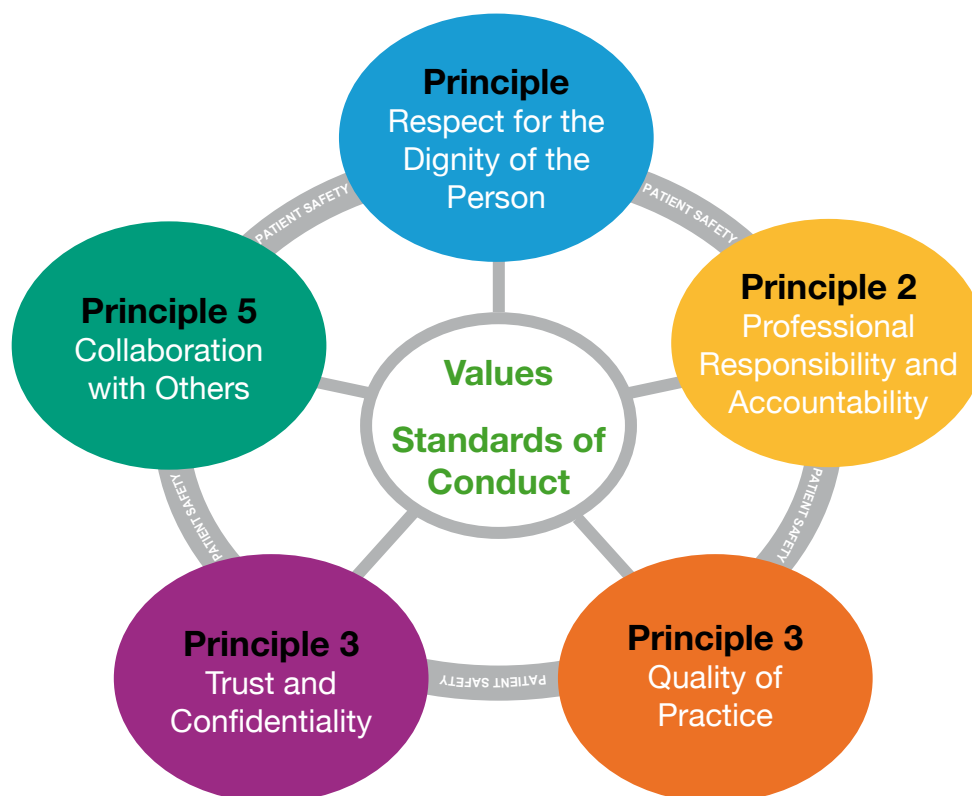


Table 7: Clinical Supervision and the Five Principles of the Code of Conduct and Ethics for Registered Nurses and Registered Midwives (NMBI, 2014).

### Principle 1: Respect for the Dignity of the Person

The principle of respect for the dignity of the person can be enhanced through Clinical Supervision by encouraging active participation in reflective practice. Discussing real workplace experiences offers opportunities for Mental Health Nurses to discuss, receive support and to learn from the varied encounters that are managed within the healthcare environment. These discussions may include considerations of the uniqueness of care required by service users, ethical dilemmas, managing cultural diversity, issues of consent, capacity, and the challenges of teamwork.

### Principle 2: Professional Responsibility and Accountability

The code of professional conduct and ethics stipulates that nurses are responsible and accountable for all aspects of their clinical practice and must therefore maintain high standards of professional conduct. Adherence of this principle requires constant reflective practice regarding every intervention that is conducted by a nurse in providing care to service users. Clinical supervision provides allocated time for the nurse to reflect and discuss the care they provide along with colleagues. It offers a method of promoting transparency of care and enhancing accountability. In reflecting on work related experiences, the nurse is encouraged to consider multiple perspectives including ethical and professional values, professional boundaries, advocacy and evaluation of the provision of care. Clinical supervision also provides an opportunity for nurses to consider and discuss the impact that work related experiences have on their own well-being. It provides a supportive forum for each nurse to express difficulties they may be experiencing within the workplace and to discuss how they are best managed. It also offers a forum for highlighting and addressing practice that may fall short of requisite quality standards.

### Principle 3: Quality of Practice

Nurses “...should actively participate in good clinical governance to ensure safe, quality care...” (NMBI, 2014, p 21). Clinical governance is intrinsically linked with providing high quality, safe and effective care, and health care professionals accept accountability for this provision. Through the process of reflection in Clinical Supervision, nurses are encouraged to be accountable for the care they provide and to assess the quality and safety of the care. Participating in Clinical supervision also provides an opportunity for the nurses to consider their emotional reactions to managing work related challenges and events. It is often through discussion with peers that clinicians become more emotionally aware of how they respond to work related situations. Participating in Clinical supervision promotes reflection upon emotional reactions and encourages alternative methods of managing difficult experiences. This provides informal learning for all participants and is therefore a means of continuing professional development and maintaining professional competency.

### Principle 4: Trust and Confidentiality

The act of discussing care of service users openly and transparently with peers promotes honesty, integrity and safety for service users and colleagues, and supports the enhancement of professional judgment in managing complex work related encounters. This always occurs within a context of maintaining high standards relating to confidentiality for both nurses and service users.

### Principle 5: Collaboration with Others

Participating in clinical supervision can enhance collaboration within the work environment. Through a process of discussing and challenging practice, clinical supervision can promote personal change, enhance clinical practice, and facilitate cultural change within a work environment.

(HSE, 2017b)

## 3.11 Conclusion

This chapter has provided guidance on clinical supervision in practice, including;

- The formats of clinical supervision,
- The supervisory relationship,
- Negotiating and developing a clinical supervision agreement,
- Ethical considerations.

The chapter has also explored the concept of reflective practice and provided guidance for giving and receiving feedback and for undertaking evaluation within the clinical supervision relationship. Models of reflective practice have been outlined which illuminate a path to creating a reflexive space where learning, growth and development of the supervisor and supervisee can occur.



# Chapter Four:

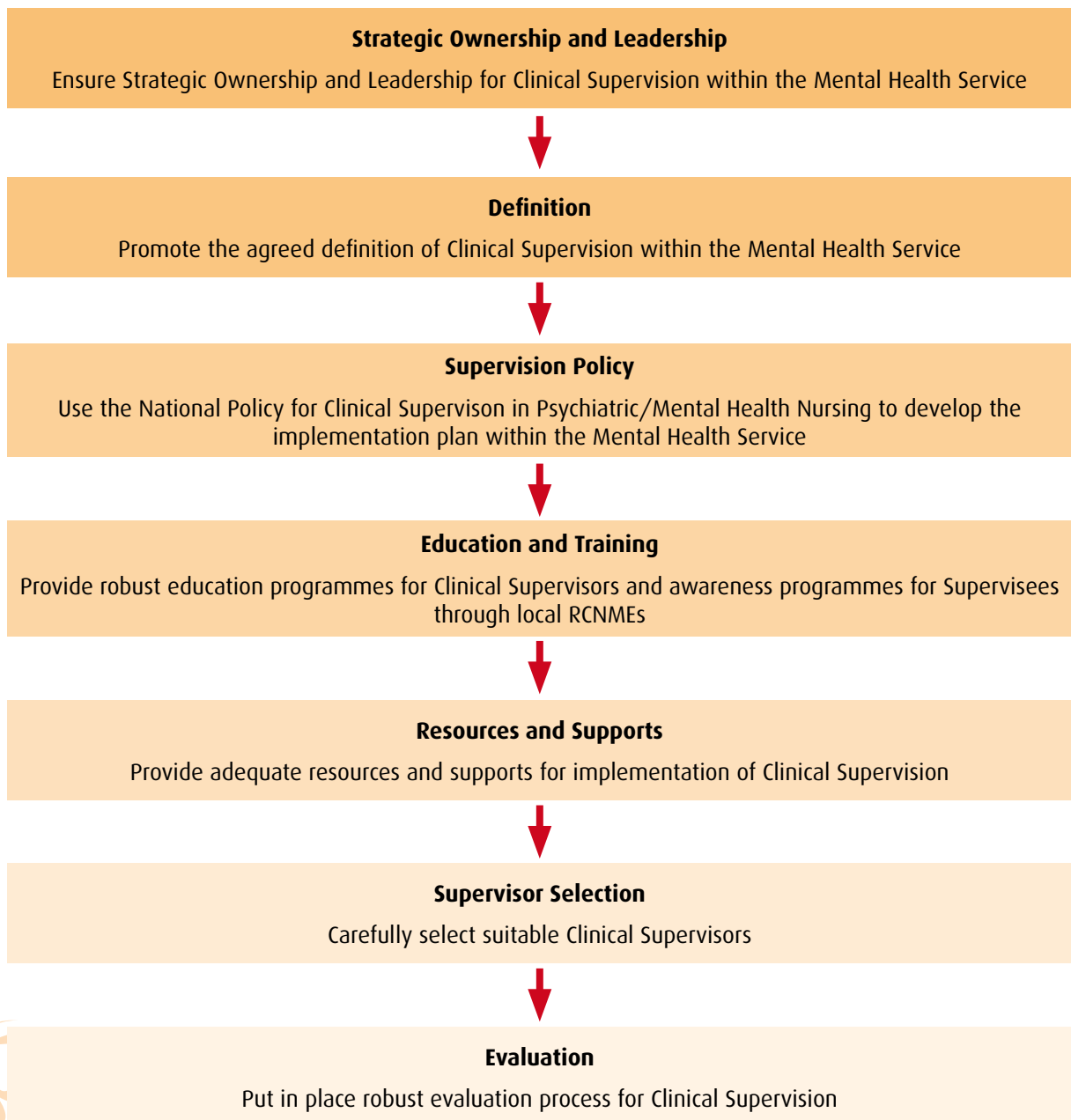
## Implementing Clinical Supervision

### 4.1 Introduction

This chapter provides guidance on the effective implementation of clinical supervision for nurses working in Mental Health Services across the HSE. It clarifies the steps required for implementation, examines the factors which support an effective implementation strategy and provides a clinical supervision in mental health/psychiatric exemplar policy that services may adapt to support the implementation of clinical supervision.

Figure 7 below and the following sections outline the process and supporting implementation evidence to implement clinical supervision for nurses within Mental Health Services.

Figure 7: Process for Implementation of Clinical Supervision



## 4.2 Strategic Ownership and Leadership

The Health Services People Strategy, *Leaders in People* (HSE, 2015c) emphasises the importance of nurturing leaders who drive initiatives and inspire innovation within the health service which will ultimately lead to better and safer healthcare. Organisational investment and commitment is required, involving all key stakeholders- clinicians, supervisors, managers, policy makers, educators and researchers - to ensure effective implementation can be achieved (Cleary et al., 2010; Sloan and Grant, 2012).

Strategic support and ownership within the organisation is essential in the effective introduction of clinical supervision. Therefore managers at all levels need to:

- actively engage and support the process,
- recognise the importance of effective leadership in implementation and
- assess the potential impact of organisational culture on the supervisory process.

The following points may guide nurse managers with the successful implementation of clinical supervision.

- The value an organisation places, and is seen to place, on supervision impacts on successful implementation. Therefore consistent, clear and visible leadership is crucial to the introduction and implementation of clinical supervision.
- Clinical supervision should be offered to Mental Health Nurses on a voluntary basis.
- It is important that clinical supervision is seen as a component of Mental Health Nursing work and participation should be seen as an activity that is part of their day to day work.
- All key stakeholders need to be clear about the purpose, nature and processes involved in clinical supervision within the service.
- Resources are required to ensure the successful implementation and sustainability of clinical supervision.
- All Mental Health Nurses should have equal access to clinical supervision within the service.
- Each Mental Health Service should develop a written implementation plan for clinical supervision in Mental Health Nursing.

## 4.3 Definition

- Promote the agreed definition of clinical supervision as outlined in Chapter 1.
- This definition should be visible in all operational guidelines, policies and procedures pertaining to clinical supervision.

## 4.4 Policy

A national “Clinical Supervision in Psychiatric/Mental Health Nursing” policy has been developed. It is recommended that Mental Health Services develop an implementation plan locally to support the ongoing development of effective clinical supervision processes within their services.



## 4.5 Education and Training

Within the Irish context the importance of education in supporting the implementation of clinical supervision is endorsed by the HSE's National Clinical Supervision guidance documents (HSE, 2015a; 2015b).

- Preparation is essential for effective delivery and uptake. Therefore there should be an emphasis on education sessions prior to and during the introduction of clinical supervision (ACES, 2011).
- Supervisees require induction, training and preparation as well as supervisors. Therefore training programmes need to be provided for all participants in the supervisory process. Supervisors, supervisees and managers alike require education on the purpose, process and practice of clinical supervision which is appropriate to their role.
- Clinical supervisors require specific training on theoretical models and practical dimensions of clinical supervision.
- Nurses may benefit from experimenting with a range of approaches to clinical supervision. Therefore education providers should offer inputs on a range of conceptual frameworks, models and formats for supervision and also include supervision skills practice.

The Clinical Supervision National Mental Health Group designed and developed a three day education programme '*An Introduction to the Theory and Practice of Clinical Supervision*' to provide supervisors with the skills and knowledge required to undertake their role. This education programme was informed by national and international evidence, is approved by the Nursing and Midwifery Board of Ireland and can be accessed through Regional Centres of Nursing & Midwifery Education Centres (RCNMEs). The module descriptor and details of the education programme are included in the overall clinical supervision resource pack and available on the ONMSD website.

## 4.6 Resources and Supports

Rice et al., (2007) offer a list of practical recommendations regarding organisational and supervisor factors which support the implementation of clinical supervision within an organisation.

### 4.6.1 Organisational Supports

- An implementation committee/steering group should be established to oversee the implementation of clinical supervision.
- Resources will be required to support Implementation (budgetary/facilities).
- Allocate protected time within the working day for supervisors and supervisees to fully participate in supervision.
- The time allocated for supervision should reflect the needs of supervisees, their stage of career progression, the format of supervision and organisational resources.



- There needs to be an adequate number of supervisors trained to meet current and emerging needs within each service.
- Supervision forums for supervisors should be established. These should provide oversight, support and a learning space for reflection on the supervisor's supervisory work, essentially providing supervision for supervisors.

#### 4.7 Supervisor Selection

Clinical supervisors must have sound clinical skills, a strong knowledge base and be a practising clinical Mental Health Nurse. They should demonstrate clear commitment to the role of clinical supervisor and possess qualities which include being able to reflect in supervision, be reliable, trustworthy, supportive and interested. They must have the ability to act effectively when needed and have the capacity to inspire supervisees to reflect on and evaluate their clinical and therapeutic work to enhance their learning.

(Rice et al., 2007, p520)

Potential supervisors should:

- Be registered with the Nursing and Midwifery Board of Ireland (NMBI),
- Possess 5 years post registration clinical experience in mental health nursing,
- Have an interest in the area of supervision,
- Be prepared to undertake 3 day NMBI approved education programme to equip them with the skills and competencies to undertake the role of supervisor,
- Be prepared to participate in their own regular supervision, and
- Be committed to Continuing Professional Development (CPD).

#### 4.8 Evaluation

It is recommended that appropriate governance structures be established to evaluate clinical supervision. This may include periodic review, audit and evaluation to ensure quality of the supervision process.

A mechanism for collecting data and information that will inform evaluation of supervisory processes and outcomes should be developed.

#### 4.9 Conclusion

This chapter provides guidance on the effective implementation of clinical supervision for nurses and their managers working in Mental Health Services across the HSE.



# Chapter Five:

## Conclusion

### 5.1 Overview

This guidance document has systematically provided evidence, rationale and practical guidance on the utilisation of clinical supervision for nurses working in Mental Health Services in Ireland. In providing the evidence supporting supervision, it is acknowledged that clinical supervision has become progressively recognised as an essential aspect of modern, effective health care delivery. The benefits have been outlined and include the development of professional skills and competence; prevention of stress and burnout; reduced sick leave; improved job satisfaction; increased feeling of being valued; improved self-esteem; enhanced personal and professional development; and the promotion of safe and effective evidence based practice.

The concepts of reflective practice and learning which are central to effective clinical supervision for Mental Health Nursing have been explored and a framework has been outlined for giving and receiving feedback.

This publication provides guidance on: clinical supervisory practice with a specific focus upon formats and delivery within Mental Health Services; how to develop effective supervisory relationships; and the importance of negotiating a clinical supervision agreement. Practical aspects for the introduction of clinical supervision are provided. This document forms part of an overall collection of resources that outlines the process for the effective implementation of clinical supervision for nurses working in Mental Health Services in Ireland.

In addition to this guidance document, resources include:

- A Frequently Asked Questions (FAQ) document to support clinical supervision promotion within Mental Health Services,
- A national policy from which services can develop an implementation plan,
- A template for a Clinical Supervision Agreement (Appendix II),
- A Module Descriptor and supporting documents for *An Introduction to Theory and Practice of Clinical Supervision* (3 day education programme),
- A decision support framework for a potential breach of Code of Practice/Ethics arising during Clinical Supervision (Appendix III).





## References

- ACES (2011) *Best Practices in Clinical Supervision ACES Task Force Report*, available at <https://www.wcu.edu/WebFiles/PDFs/AcesBestPractices.pdf> (accessed 22/12/18).
- Alleyne, J. and Jumaa, M. (2007) 'Building the Capacity for Evidence-based Clinical Nursing Leadership: The Role of Executive Co-Coaching and Group Clinical Supervision for Quality Patient Service', *Journal of Nursing Management*, 15, 2, 230-243.
- Benner, P. (1984) From novice to expert. *American Journal of Nursing*, 82 (3), 402-407.
- Bennett-Levy, J. (2006) Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, 34, 57-78.
- Bernard, J. M. and Goodyear, R.K. (2014) *Fundamentals of Clinical Supervision*, London, Pearson.
- Bernard, J. M., and Goodyear, R. K. (2004) *Fundamentals of clinical supervision* (3rd ed.). Needham Heights, MA, US: Allyn & Bacon.
- Bordin, E. S. (1983) Supervision in counselling: II. Contemporary models of supervision: A working alliance based model of supervision. *Counselling Psychologist*, 11, 35-42.
- Bond, M., and Holland. S. (2010) *Skills of Clinical Supervision for Nurses*. 2<sup>nd</sup> ed. Maidenhead: Open University Press.
- Boyd, E. M., and Fales, A. W. (1983) Reflective Learning: Key to Learning from Experience. *Journal of Humanistic Psychology*, 23(2), 99-117.
- Bradshaw, T., Butterworth, A. and Mairs, H. (2007) 'Does Structured Clinical Supervision During Psychosocial Intervention Education Enhance Outcome for Mental Health Nurses and the Service Users They Work With?' *Journal of Psychiatric and Mental Health Nursing*, 14: 4-12.
- Brunero, S. and Stein-Parbury, J. (2008) 'The Effectiveness of Clinical Supervision in Nursing: An Evidenced Based Literature Review', *Australian Journal Of Advanced Nursing*, 25 (3)
- Butterworth, T., Bell, L., Jackson, L., and Pajnikihar, M. (2008) 'Wicked Spell or Magic Bullet? A Review of the Clinical Supervision Literature 2001-2007', *Nurse Education Today*, 28, pp 264-272.
- Butterworth, T. and Faugier, T. (1992) *Clinical Supervision and Mentorship in Nursing*, New York, Springer.
- Buus, N., Angel, S., Traynor, M., and Gonge, H. (2011) Psychiatric nursing staff members' reflections on participating in group-based clinical supervision: A semi-structured interview study. *International Journal of Mental Health Nursing*, 20 (2), 95-101.
- Care Quality Commission (2013) *Supporting Information and Guidance. Effective Clinical Supervision*. London: Care Quality Commission.
- Carroll, M and Gilbert, M. (2011) *On Being a Supervisee: Creating Learning Partnerships* (2nd ed). London: Vukani Publishing.
- Cleary, M. and Freeman, A. (2006) Fostering a culture of support in mental health settings: Alternatives to traditional models of clinical supervision. *Issues in Mental Health Nursing*. Vol. 27(9): 985-1000.
- Cleary, M., Horsfall, J. and Happell, B (2010) 'Establishing Clinical Supervision in Acute Mental Health Inpatient Units: Acknowledging the Challenges', *Issues in Mental Health Nursing*, 31:525-531.
- Cookson, J., Sloan, G., Drafters, R. and Jahoda, A. (2014) 'Provision of Clinical Supervision for Staff Working in Mental Health Services', *Mental Health Practice*, 17: 7, 29 -34.



Davys, A. and Beddoe, L. (2010) *Best Practice in Professional Supervision; A Guide for the Helping Professions*, London: Jessica Kingsley Publishers.

Department of Health (2006) *From Values to Action: The Chief Nursing Officer's Review of Mental Health Nursing*, Department of Health, London.

Department of Health, NI, (2008) *Supervision Policy, Standards and Criteria: Regional Policy for Northern Ireland Health and Social Care Trusts*. Belfast: Department of Health, Social Services and Public Safety.

Department of Health, (2016) Values for Nurses and Midwives in Ireland, Position Paper One, Office of the Chief Nurse, DoH June 2016, Accessible via <https://health.gov.ie/wp-content/uploads/2017/08/Position-Paper-One-Values-for-Nurses-and-Midwives-in-Ireland-June-2016.pdf>

Driscoll, J. (2007) *Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals*. (2nd edition). Edinburgh: Bailliere Tindall Elsevier.

Edwards, D., Cooper, L., Burnard, P., Hannigan, B., Adams, J., Fothergill, A., and Coyle, D. (2005) 'Factors Influencing the Effectiveness of Clinical Supervision', *Journal of Psychiatric and Mental Health Nursing*, 12, 405-414.

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil A. and Coyle, D. (2006) 'Clinical Supervision and Burnout: The Influence of Clinical Supervision for Community Mental Health Nurses' *Journal of Clinical Nursing* 15, 1007-1015

Egan, G. (1994) *The skilled helper* (4th Ed.), Pacific Grove, California: Brookes/Cole.

Ellis, M. (2010) Bridging the Science and Practice of Clinical Supervision: Some Discoveries, Some Misconceptions, *The Clinical Supervisor*, 29:1, 95-116, DOI: <https://doi.org/10.1080/07325221003741910>

Falender, C. A., and Shafranske, E. P. (2004) *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Falender, C.A., and Shafranske, E.P. (2007) Competence in competency based supervision practice: Construct and application. *Professional Psychology, Research and Practice*, 38(3), 232-240.

Falender, C. A. and Shafranske, E. P. (2014), Clinical Supervision: The State of the Art. *J. Clin. Psychol.*, 70: 1030-1041. doi:10.1002/jclp.22124

Fowler, J. (2011) 'Case Studies from Leicestershire UK', In J.R. Cutcliffe, K. Hyrkas and J. Fowler (Eds), *Routledge Handbook of Supervision, Fundamental International Themes*, New York, Taylor Francis Group.

Fowler, J. (1996) 'The Organization of Clinical Supervision within the Nursing Profession: A Review of the Literature', *Journal of Advanced Nursing*, 23(3), pp 471-8.

Gaitskell, S. and Morley, M. (2008) Supervision in Occupational Therapy. How are we doing? *British Journal of Occupational Therapy*. Vol. 71 (3): 119-121.

Gibbs, G. (1988) *Learning by Doing: A guide to teaching and learning methods*. Further Education Unit. Oxford Polytechnic: Oxford.

Gonge, H. and Buus, N (2015) 'Is it Possible to Strengthen Psychiatric Nursing Staff's Clinical Supervision? RCT of a Meta-Supervision Intervention', *Journal of Advanced Nursing*, 71(4):909-21.

Gonge, H. and Buus, N. (2011) 'Model for Investigating the Benefits of Clinical Supervision in Psychiatric Nursing: A Survey Study', *International Journal of Mental Health Nursing*, 20, 102-111



- Government of Ireland (2006) *A Vision for Change: Report of the Expert Group on Mental Health Policy*, Dublin, Stationery Office.
- Hawkins, P. and Shohet, R. (2012) *Supervision in the Helping Professions*. Maidenhead: Open University Press.
- HSE (2018a) *National Framework for Recovery in Mental Health*, Dublin, Health Service Executive.
- HSE (2018b) *Peer Group Clinical Supervision Framework for Nurses and Midwives working in HSE South Cork/Kerry*, Nursing and Midwifery Planning and Development Unit (Cork/Kerry)
- HSE (2018c) *Co-production in Practice Guidance Document 2018 - 2020*. HSE mental health services and Advancing Recovery Ireland
- HSE (2017a) *Best Practice Guidance for Mental Health Services*, Dublin, Health Service Executive.
- HSE (2017b) *HSE North East Nursing and Midwifery Peer Group Clinical Supervision Strategic Plan*, Dublin, HSE Office of Nursing and Midwifery Services Director.
- HSE (2015a) *Clinical Supervision Framework for Nurses Working in Mental Health Services*, Dublin, HSE Office of Nursing & Midwifery Services Director.
- HSE (2015b) *Health Service Executive Supervision for Health & Social Care Professionals: HR Circular 002/2015*, Dublin, Health Service Executive.
- HSE (2015c), *Health Services People Strategy 2015-2018*, Dublin, Health Service Executive.
- Health Service Executive (2012) *A Vision for Psychiatric/Mental Health Nursing: A Shared Journey for Mental Health Care in Ireland*, Dublin, HSE Office of Nursing and Midwifery Services Director.
- Inskipp, F. and Proctor, B. (2001a) *Making the Most of Supervision, Part 1*. Twickenham, Cascade.
- Inskipp, F. and Proctor, B. (2001b) *The Arts, Crafts and Tasks of Counselling Supervision: Part 2 Becoming a Supervisor (2<sup>nd</sup>ed)*. London: Cascade.
- Jones, A. (1996) 'Clinical supervision: a framework for practice', *The International Journal of Psychiatric Nursing Research*, 3, 1, 290-307.
- Kennerley, H., and Clohessy, S. (2010) Becoming a supervisor In: M. Mueller, H. Kennerley, F. McManus, & D. Westbrook 323-370. *Oxford guide to surviving as a CBT therapist*. Oxford: Oxford University Press.
- Kolb, D.A. (1984) *Experiential Learning: Experience as the Source of Learning and Development*. Prentice-Hall Inc, Englewoods Cliffs, NJ
- Lynch, L., and Happell, B. (2008a) 'Implementing Clinical Supervision: Part 1: Laying the Ground Work', *International Journal of Mental Health Nursing*, 17(1), 57-64.
- Lynch, L., and Happell, B. (2008b) 'Implementing Clinical Supervision: Part 2: Implementation and Beyond', *International Journal of Mental Health Nursing*, 17(1), 65-72.
- MacCulloch, T. and Shattell, M., (2009) 'Clinical Supervision and The Well-being of the Psychiatric Nurse'. *Issues in Mental Health Nursing*, 30(9), p.589-590.
- MaLaren, J., Stenhouse, R. and Ritchie, D. (2016) 'Mental Health Nurses Experiences of Managing Work-Related Emotions Through Supervision', *Journal of Advanced Nursing* 72(10), 2423-2434.
- Martin, P., Copley, J. and Tyack, Z. (2014) Twelve tips for effective clinical supervision based on a narrative literature review and expert opinion. *Medical Teacher*. 36:3. 201-207.
- Milne, D. and James, I. (2005) Clinical supervision: 10 tests of the tandem model. *Clinical Psychology Forum*, 151, 6-9.



- Milne, D. (2007) 'An Empirical Definition of Clinical Supervision', *British Journal of Clinical Psychology* 46, 437-447.
- Milne, D. (2009) Evidence-Based Clinical Supervision. BPS -Blackwell.
- Munsen, CE. (2002) 3rd Edition. *Handbook of Clinical Supervision*. NY: Howorth Social Work Practice Press.
- NMBI, (2015) *Scope of Nursing and Midwifery Practice Framework*, Dublin, Nursing & Midwifery Board of Ireland.
- NMBI, (2014) *Code of Professional Conduct and Ethics*, Dublin, Nursing & Midwifery Board of Ireland.
- Page, S., and Wosket, V. (2015) *Supervising the Counsellor and Psychotherapist: A Cyclical Model* (3rd ed.), New York, Routledge/Taylor & Francis Group.
- Page, S. and Wosket, V. (2001) *Supervising the Counsellor: A Cyclical Model*, (2<sup>nd</sup> Ed) London, Routledge.
- Prasko, J., Vyskocilova, J., Slepecky, M., and Novotny, M. (2012) Principles of supervision in cognitive behavioural therapy. *Biomed Pap Medical Faculty Palacky Olomouc Czech Republic Mar*; 156(1); 70-79.
- Pritchard, J. (1995) Good Practice in Supervision: Statutory and Voluntary Organisations. London: Jessica Kingsley Publishers.
- Proctor, B. (2001) Training for the supervision alliance, attitude, skills and intention. In J.R Cutcliffe, T. Butterworth, and B. Proctor (2001), *Fundamental themes in clinical supervision*. London and New York: Routledge.
- Proctor, B. (2011) Training for the supervision alliance. Attitude, skills and intention. In J.R. Cutcliffe, K.Hyrkas, and J. Fowler (Eds), *Routledge handbook of clinical supervision fundamental international themes*. London and New York, Routledge.
- Proctor, B. (2008) *Group Supervision: A Guide to Creative Practice* (Counselling Supervision series), London, Sage.
- Proctor, B. (1986) Supervision: A Cooperative Exercise in Accountability. in M. Marken and M. Payne (Eds), *Stories in Mental Health: Reflection, Inquiry, Action*, National Youth Bureau, Leicester, pp 21-23.
- Pront, L, Gillman, D. and Schuwirth W.T. (2016) 'Competencies to Enable Learning-Focused Clinical Supervision: a Thematic Analysis of the Literature' *Medical Education* 2016: 50: 485-495
- Reid, B. (1993) 'But we're doing it already!' Exploring a response to the concept of reflective practice in order to improve its facilitation. *Nurse Education Today*, 13, 305-309.
- Reiser, R. P., and Milne, L., (2014) 'A Systematic Review and Reformulation of Outcome Evaluation in Clinical Supervision: Applying the Fidelity Framework', *Training and Education in Professional Psychology*, Vol 8(3), p149-157
- Rice, F., Cullen, P., McKenna, H., Kelly, B., Keeney, S. and Richey, R. (2007) 'Clinical Supervision for Mental Health Nurses in Northern Ireland: Formulating Best Practice Guidelines', *Journal of Psychiatric and Mental Health Nursing*, 14: 516-521.
- Royal College of Nursing (2003) *Clinical Supervision in the Workplace: Guidance for Occupational Health Nurses*: London.
- Shohet, R. (2011) *Supervision as Transformation*. London: Jessica Kingsley.

- Schön, D. (1983). *The Reflective Practitioner: How professionals think in action*. London: Temple Smith.
- Scottish Executive (2010) *Rights, Relationships and Recovery Refreshed. The Report of the National Review of Mental Health Nursing in Scotland. Action Plan 2010–2011*. The Scottish Executive, Edinburgh.
- Scottish Executive (2006) *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland Delivery Action Plan*. The Scottish Executive, Edinburgh.
- Sloan, G. and Grant, A. (2012) 'A Rationale for a Clinical Supervision Database for Mental Health Nursing in the UK', *Journal of Psychiatric and Mental Health Nursing*, 19, 466–473.
- Snowdon, D.A, Hau, R., Leggat, SG, and Taylor, N.F. (2016) 'Does Clinical Supervision of Health Professionals Improve Patient Safety? A Systematic Review and Meta-analysis', *International Journal for Quality in Health Care*, 2016, 28(4), 447–455.
- Stoltenberg, C. D., Mc Neil, B.W., and Delworth, U. (1998) *IDM Supervision: An integrated model for supervising counsellors and therapists*. San Francisco, CA: Jossey-Bass.
- Thompson, S. and Thompson, N. (2008) *The critically reflective practitioner*. Basingstoke, New York: Palgrave Macmillan.
- Turner, J. and Hill, A. (2011). Implementing clinical supervision (part1): a review of the literature. *Mental Health Nursing*, 31 (3) 8-12.
- Von de Pol, J., Volman, M. and Beishuizen, J. (2010) Scaffolding in Teacher – Student Interaction: A Decade of Research. *Educational Psychology Review: Vol. 22, Issue 3*, p 271-296.
- Van Oojen, E. (2000) *Clinical Supervision: A Practical Guide*: Churchill and Livingstone: United Kingdom.
- Watkins, C.E. (2011) 'Does Psychotherapy Supervision Contribute to Patient Outcomes? Considering Thirty Years of Research', *The Clinical Supervisor*, 30:2, 235-256.
- White, E and Winstanley, J. (2010) 'A Randomised Controlled Trial of Clinical Supervision: Selected Findings from a Novel Australian Attempt to Establish the Evidence Base for Causal Relationships with Quality of Care and Patient Outcomes, As An Informed Contribution to Mental Health Nursing', *Journal of Research in Nursing*, 15 (2) 151-167.
- White, E. and Roche, M. (2006) 'A Selective Review of Mental Health Nursing in New South Wales, Australia, in Relation to Clinical Supervision' *International Journal of Mental Health Nursing*, 15, 209–219.
- Woskett, V. and Page, S. (2001) 'The Cyclical Model of Supervision; A Container for Creativity and Chaos' in M. Carroll and M. Tholstrup (Eds), *Integrative Approaches to Supervision*, London, Jessica Kingsley Publishers.
- Wright, J. (2012) 'Clinical supervision: a review of the evidence base', *Nursing Standard*, 27. 44-9. 10.7748/ns2012.09.27.3.44.c9298.

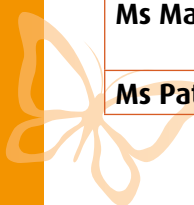


# Appendices

## Appendix 1

### National Group for Clinical Supervision in Mental Health Services: Membership

Name	Title	Organisation
<b>Dr James O'Shea</b> Co-Chairperson	Director of Nurse Education, Mental Health (Director of Regional Centre of Nursing & Midwifery Education from April 2018 onwards)	Office of the Nursing and Midwifery Services Director (ONMSD) & Mental Health Services
<b>Ms Liz Roche</b> Co-Chairperson	Area Director NMPD – DML	Office of the Nursing and Midwifery Services Director (ONMSD)
<b>Ms Caroline Kavanagh</b>	Nurse Tutor	Nursing & Midwifery Planning & Development, Dublin North
<b>Ms Anne Buggy</b>	Area Director Mental Health Nursing	HSE Carlow, Kilkenny, South Tipperary Mental Health Services
<b>Ms Caitriona McDonagh</b>	Area Director Mental Health Nursing	HSE North Dublin Mental health Services
<b>Ms Anne Brennan</b>	Director - Nursing & Midwifery Planning & Development	HSE Dublin North
<b>Ms Sinead Connaire</b>	NMPD Officer	HSE South (Cork & Kerry)
<b>Mr Con Buckley</b>	Service User representative	
<b>Ms Aisling Culhane</b>	Research & Development Advisor	Psychiatric Nurses Association
<b>Ms Gina Delaney</b>	Family Member & ARI Representative	Advancing Recovery In Ireland – HSE MHD
<b>Ms Imelda Noone</b>	Practice Development Coordinator	HSE Dublin North City Mental Health Services
<b>Ms Tina Nutley</b>	Clinical Nurse Specialist & Clinical Supervisor Mental Health Nursing	National Forensic Mental Health Services
<b>Ms Lucy Roberts</b>	Registered Advanced Nurse practitioner & CBT Therapist/ Clinical Supervisor - Mental Health Nursing	HSE Carlow Kilkenny, South Tipperary Mental Health Services
<b>Ms Maureen McCafferty</b>	Assistant Director of Mental Health Nursing & Clinical Supervisor Mental Health Nursing	HSE, Waterford/Wexford Mental Health Services
<b>Ms Mairead Mc Gahon</b>	Interim Director Centre of Nurse Education	HSE Centre for Nurse Education, Ardee
<b>Ms Patricia O'Neill</b>	Service Improvement Lead	HSE Mental Health Services



## Appendix II

### Sample Clinical Supervision Agreement

Name of Supervisor:	Name of Supervisee(s):	
Period of this Agreement:		
<b>Start Date:</b>	<b>End Date:</b>	<b>Review Date:</b>
<b>Objectives</b>		
<i>Supervisee</i>		
<u>Restorative</u>		
<ul style="list-style-type: none"> <li>• To discuss clinical scenarios that I have faced, in a manner that is supportive and constructive.</li> <li>• To reflect on my responses to the challenges and issues I face in clinical practice.</li> <li>• To reflect on my responses to the challenges and issues I face in providing clinical supervision.</li> <li>• To identify transference and counter-transference and prevent it from impairing my ability to work safely.</li> </ul>		
<u>Formative</u>		
<ul style="list-style-type: none"> <li>• To improve skills and knowledge in delivering clinical services.</li> <li>• To improve skills and knowledge in the practice of providing education.</li> <li>• To improve skills and knowledge in the art and craft of clinical supervision.</li> </ul>		
<u>Normative</u>		
<ul style="list-style-type: none"> <li>• To stay orientated to best-practice by checking adherence to regulatory and national legislation.</li> <li>• To ensure that my clinical practice &amp; clinical supervision roles are each performed within the boundaries of best practice as determined by the HSE (2019, 2018, 2017, 2015, 2012), the Mental Health Commission (MHC) &amp; the Nursing &amp; Midwifery Board of Ireland (NMBI).</li> </ul>		
<b>Supervisor</b>		
<ul style="list-style-type: none"> <li>• To assist the supervisee meet their objectives</li> </ul>		
<b>Expected Outcomes</b>		
<i>Supervisee</i>		
Over the course of this agreement these outcomes will be met:		
<u>Restorative</u>		
<ul style="list-style-type: none"> <li>• To have discussed clinical scenarios that I have faced, in a manner that is supportive and constructive.</li> <li>• To have reflected on my responses to the challenges and issues I face in instances of my clinical practice.</li> <li>• On occasions explore transference and counter-transference and the impact it has on my ability to work safely.</li> </ul>		



Formative

- To have provided quality clinical practice for the service users I have been referred.
- To recognise occasions when my clinical practice has been below par, and attempt to redress the underlying cause(s) of this.
- To have provided quality clinical supervision.

Normative

- That my clinical supervision be informed by the HSE best-practice guidance (HSE, 2012, 2015, 2017, 2108, 2019).
- That my clinical practice & clinical supervision role have been performed within the boundaries of best practice as determined by the HSE, NMBI and the MHC.

## Supervisor

- By reflecting well on the goals \_\_\_\_\_ and I have agreed upon, he/she will have improved and consolidated his/her competency, capability and capacity in his/her mental health nursing role as well as making the transition with greater confidence into his/her role in clinical supervision. We will measure the progress through our regular reviews within supervision.

**Obligations**

## Supervisee

- Demonstrate the value placed on clinical supervision by setting time aside for clinical supervision from other appointments and interruptions

## Supervisor

- To set aside sufficient time before meeting with Supervisee to ready myself for quality reflection with him/her by disengaging from other commitments.

**Structure**

**Frequency:** Clinical Supervision will be provided every \_\_\_\_\_ weeks

**Duration:** Clinical Supervision will last approximately \_\_\_\_\_ minutes

**Location:** Clinical Supervision will be held \_\_\_\_\_

**Resources:** Time & venue with an absence of interruptions

**Cancellations:** Cancellations will be made at least 24 hours before anticipated clinical supervision session (where possible)

**Agenda:** Supervisee to set simple agenda and email to the supervisor a day or two previously. The supervisor may add/amend agenda as necessary

**Evaluation**

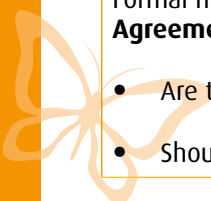
What is the agreed process for evaluation of clinical supervision?

- Wrap-up discussion at the end of session to include a mutual check between Supervisor and Supervisee on whether the goals of supervision are being adequately addressed
- If the Supervision relationship itself is causing problems, the Supervisor and/or Supervisee will ensure that this matter is included on the agenda for the next session

Every 12 Months

Formal mutual evaluation of supervision will be conducted every 3 months using this Clinical Supervision **Agreement:**

- Are the objectives/outcomes being met?
- Should the agreement/objectives be modified?





### Review of the Supervision Agreement

- The agreement should be reviewed if the objectives, expected outcomes, obligations, or structure of clinical supervision change.
- Mutual review a month prior to the end-date of this agreement to allow time for extension or conclusion of the agreement & the supervisory relationship

### Documentation/Records

What form will supervision records take?

- Clinical Supervision Agreement
- Clinical Supervision Recording Notes
- Clinical Supervision Record of Attendance
- It is understood that notes regarding supervision will be more extensive and detailed if there are concerns about clinical competence/client safety. This will be done in a transparent manner where both Supervisee and Supervisor will have access to the clinical supervision record.

How will these supervision records be used?

- To assist the Supervisee & Supervisor reflect on their work
- As an adjunct to the Clinical Supervision Evaluation process
- As a record of Clinical Supervision

Who will have access to them and in what circumstances?

Under usual circumstances:

- Supervisee
- Supervisor

When there are concerns about clinical competence/client safety:

Line Management. This will be done in a transparent manner where both Supervisee(s) and Supervisor are fully informed of the rationale.

### Ethical Issues

How will difficulties in supervision be dealt with?

Difficulties in supervision initially to be discussed between supervisor and supervisee either at the time an issue arises or at the commencement of the next meeting.

### Confidentiality

Confidentiality and trust underpin all clinical supervision sessions. Professional and clinical issues disclosed are confidential and must not be discussed outside the supervision sessions. The exceptions to this will be outlined in the clinical supervision agreement and may include circumstances where a supervisee discloses information which is deemed to compromise the safety of a service user, colleague or the supervisee themselves and a decision will be made to disregard confidentiality. This is in accordance with NMBI Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives (2014) - Principle 5, Standard 4

### Content

The content of Clinical Supervision will be negotiated in confidence by the Supervisee(s) and Supervisor. It will include a list of the knowledge and skills that the Supervisee(s) would like to develop, and will be regularly reviewed and renegotiated.

### Signatures & Date:

**Supervisee(s):**

**Supervisor:**



## Appendix III

### Decision Support Framework for a Potential Breach of Codes of Practice/Ethics Arising During Clinical Supervision

Issue arising during supervisory session for supervisee and supervisor

Consult supervisory protocols and ethical guidelines. Able to resolve.

No

Yes

If appropriate, supervisor brings to supervisory session to discuss/explore with supervisee. Able to resolve.

No

Yes

Supervisor encourages supervisee to bring to the attention of supervisee Line manager. Able to resolve.

No

Yes

Supervisor informs supervisee of his/her professional expectations re Code of Practice, able to resolve

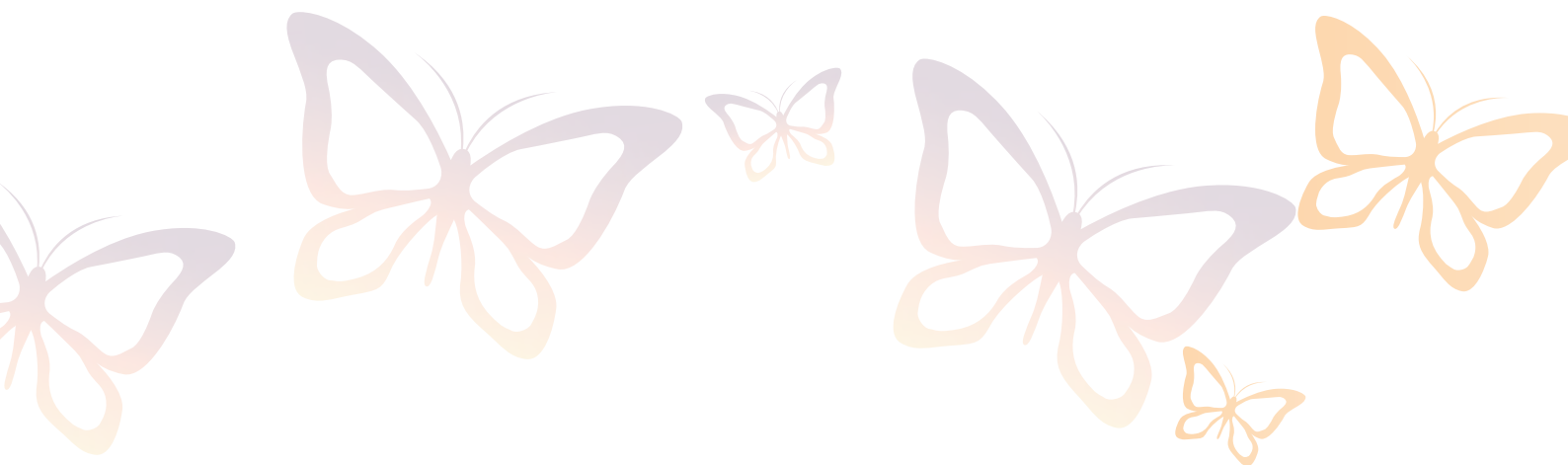
No

Yes

Supervisor brings to the attention of the supervisee's line manager and/or Supervision group

It is acknowledged that Clinical Supervision is a confidential process and that all parties have a shared understanding that any breaches of codes of ethics or practice will be addressed according to organisational policies and codes of conduct, respectfully and in a timely manner. This is a decision support framework; one may skip to different stages depending on issue or if there are serious concerns that require urgent action.





Office of the Nursing and Midwifery Services Director,  
Health Service Executive,  
Dr. Steevens' Hospital  
Dublin D08 W2A8  
Ireland  
Telephone: +353 1 6352471  
Email: [nursing.services@hse.ie](mailto:nursing.services@hse.ie)  
[www.hse.ie](http://www.hse.ie)



Office of the  
Nursing & Midwifery  
Services Director



HSE Mental Health Service

ISBN: - 978-1-908972-16-3

Copyright 2019, all rights reserved.