Use of Models in Clinical Supervision

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Focus of the Presentation

- The context of health care
- Frameworks for supervision in health care
- Examples of framework application
- Evidence of effectiveness
Context of Health Care - Western

- Hierarchical system of oversight
- **Clinical** supervision is a major emphasis because of:
  - Concern for patients
  - Current re-emphases on patient safety
  - Reimbursement & certification regulations
  - Concerns about litigation
Common Examples

- Training & education – students in all professional discipline
- Professional development requirements
- Oversight of assistant/ancillary personnel
  - Common (almost ubiquitous) in most settings, especially for nursing
  - Examples – nursing assistants in hospitals & nursing homes, home health aides, community health workers
Proctor’s Model of Supervision (1987)

- **Normative** – Administration & Quality Assurance
  - Manage projects
  - Ensure patient safety
  - Assess & assure quality
  - Improve practice

- **Restorative** – Support & Assistance with Coping
  - Identify solutions to problems in practice
  - Alleviate stress

- **Formative** – Education & Professional Development
  - Skills & knowledge
Applications of the Model

- **Normative (management, safety, assurance)**
  - Meetings
  - Observation of care
  - Formal evaluation
  - Telephone consultation
  - Documentation in hard & electronic media
    - Patient records
    - Activity logs

- **Restorative (support & assistance with coping)**
  - Group supervision
  - Case conferences
  - Identification of solutions to problems in practice

- **Formative (education & professional development)**
  - Continuing education
Heron’s Model of Supervision (1989)

- **Authoritative** Supervision Interventions
  - Prescriptive – direct behavior
  - Informative – give information/instruct
  - Confronting – challenge

- **Facilitative** Supervision Interventions
  - Cathartic – release tension/strong emotion
  - Catalytic – encourage self-exploration
  - Supportive – validate/confirm
Powell’s Model of Supervision (1993)

- **Components**
  - Administrative
  - Evaluative
  - Clinical
  - Supportive

- **Conceptualization of supervisor as a servant leader who**
  - Is self-aware
  - Operates with focus & energy
  - Is proficient in many aspects of the job
  - Makes the organizations mission & vision clear by standing ahead of the followers while standing behind their actions
  - Shares power
  - Values people by caring for them
Assumptions of Powell’s Model of Clinical Supervision (Powell, 1993)

- People have the ability to bring about change in their lives with the assistance of a guide.
- People do not always know what is best for them as they may be blinded by their resistance to & denial of the issues.
- The key to growth is to blend insight & behavioral change in the right amounts at the appropriate time.
- Change is constant & inevitable.
- In supervision, as in therapy, the guide concentrates on what is changeable.
- It is not necessary to know about the cause or function of a manifest problem to resolve it.
- There are many correct ways to view the world.
Structure of Supervision

- **Individual – 1 to 1**
  - 1 supervisor & 1 supervisee

- **Group**
  - 1 supervisor with 4-6 supervisees
  - Triad – 1 supervisor & 2 supervisees
  - Team – colleagues working together outside the group
  - Network – people not usually working together outside the group

- **Administrative Arrangements**
  - Hierarchical
  - Non-hierarchical
Supervision Venues

- Routine interactions on the job
- Informally
- In scheduled meetings
- Indirectly – e.g., by talking to patients
- Through remote communication
  - Telephone
  - Computer
  - Written documentation, e.g., logs, records, reports
Current Supervision Debates

- Qualifications of the supervisors
  - From the same discipline
  - A different discipline
  - A peer colleague
  - Expertise
    - Content of care
    - Processes of development

- Guided reflection vs. more traditional clinical supervision

- Collaborative supervision
  - May not challenge each other sufficiently (Walsh et al., 2003)
Supervision has a positive effect on patient outcome & lack of supervision is harmful to patients.

Supervision has more effect when the trainee is less experienced.

Self-supervision is not effective.

The quality of the relationship between supervisor & supervisee is probably the single most important factor for effective supervision.

Behavioral changes can occur quickly – changes in thinking & attitude take longer.
Tips

- Combine supervision with focused feedback
- Continuity
- Reflection by both participants
Characteristics of Effective Supervisors

- Empathetic
- Supportive
- Flexible
- Interested in supervision
- Track supervisees effectively
- Link theory with practice
- Engage in joint problem-solving
- Interpretative
- Respectful
- Focused
- Practical
- Knowledgeable
Characteristics of Ineffective Supervisors

- Rigid
- Low empathy
- Low support
- Failure to consistently track supervisee concerns
- Failure to teach or instruct
- Indirect & intolerant
- Closed
- Lack respect for differences
- Non-collegial
- Lacking in praise & encouragement
- Sexist
- Emphasize evaluation, weaknesses, & deficiencies
Recommended Content for Supervisor Training

- Supervision frameworks
- Assessment of learning needs
- Teaching the adult learner
- Counseling
- Provision of feedback
- Issues of power & social stratification
- Transcultural relationships
References

QUESTIONS?