The Superguide

A Supervision Continuum for Nurses and Midwives

June 2013
FIRST EDITION
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NSW GOVERNMENT Health

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A Supervision Continuum for Nurses and Midwives

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Foreword

In my twenty years in health service, I've heard many people ask: "Is supervision essential to excel in clinical practice?"

My answer is a definite YES, for two reasons.

The first reason is that effective supervision creates an atmosphere of trust and openness among people working in clinical environments. Supervision allows nurses and midwives to form bonds and engage with colleagues for them to work efficiently in demanding and at times, highly stressful, situations.

The second reason is that supervision embeds a culture of lifelong learning and reflective practice for health professionals at every stage of their careers. Supervision gives nurses and midwives an opportunity for critical reflection and also develops critical reasoning that helps identify more opportunities to teach, share and learn.

Having said that, I would go further to say that supervision in general, and clinical supervision in particular, is important because without it, we cannot deliver team-based, safe patient-centred care.

At the Health Education and Training Institute (HETI), we are committed to support health professionals in their role as clinical supervisors. To accomplish this, HETI is delighted to present the first edition of The Superguide: A Supervision Continuum for Nurses and Midwives.

This resource was developed with the help of the nurses and midwives throughout NSW, in partnership with HETI and aims to enrich the quality of supervision being provided fellow nurse and midwife supervisors in NSW.

This Superguide is the latest in a series of Superguides that provides a comprehensive suite of HETI resources for clinicians practising in NSW: The Superguide: a handbook for supervising doctors in training, 2010 and The Superguide: a handbook for supervising allied health professionals, 2011.

It is my hope that this publication will provide contemporary and practical support in a user-friendly format that you can use and share with others in the nursing and midwifery discipline.

On behalf of HETI, I would like to take this opportunity to thank all clinical supervisors for your commitment to excellent health care delivery and the development of the nursing and midwifery profession.

Heather Gray

Chief Executive
Health Education and Training Institute

June 2013

Foreword

Nurses and midwives are in a privileged position as they spend significant amounts of time with numerous consumers in a variety of contexts. Nurses and midwives provide care ranging from basic nursing needs to highly specialised areas of care, often with a degree of autonomy. Nurses and midwives practice within the multidisciplinary areas, maintaining effective communication, providing leadership, support and advice to multiple team members, patients, carers and non-clinical staff. By being constantly at the point of care, they greatly influence how to support patients by knowledge sharing, advocacy and forming unique relationships with healthcare consumers.

The practice of nursing and midwifery is underpinned by excellent training and education and addresses the National Competency Standards for Nurses and Midwives. These standards, which are used to develop curricula and provide a framework to assess students and post registration practice, also enable every nurse and midwife to assess their own practice based on best available evidence of what constitutes safe and ethical care.

In tandem with these standards, the nursing and midwifery profession has understood and incorporated concepts of supervision across the continuum of professional development. Whilst there remains a lack of consensus regarding some definitions, the process undertaken to develop this guide has attempted to navigate these definitions by incorporating multiple consultations across the healthcare arena. Some areas of practice - such as mental health - are more developed than others whilst many aspire to further their knowledge and experience of types of supervision, or implement it for staff.

This guide builds on existing knowledge and, for the first time, brings together components of supervision within one document. It does not present an in-depth analysis of each area of supervision; its purpose is to give readers an overview of supervision that will encourage further discussion within the clinical environment.

In addition, the guide was produced to be a quick reference to review key principles or to accomplish specific supervision tasks. With this in mind, an accompanying toolkit and set of resources have been designed to help nurses and midwives in their day-to-day practice.

This guide is practical, user-friendly and concise. It provides definitions, tips and examples of tools to support supervision and uses a range of real-life scenarios to demonstrate the various methods. The term patient used in this guide refers to all consumers of healthcare. It is a significant resource for nurses and midwives working in contemporary healthcare, across all settings and stage of career. The information contained is vital to all who aspire to provide the best contemporary healthcare.

All nurses and midwives are responsible for their own professional development and contributing to quality health care through lifelong learning and education, both of themselves and others in the team. Therefore, it is hoped that this resource will be embraced by the profession as supporting that journey.

Sue Hendy

Director Nursing and Midwifery
Health Education and Training Institute

June 2013

Acknowledgements

This guide was prepared by the HETI Nursing and Midwifery Portfolio in collaboration with numerous individuals and organisations, health services, managers, expert working groups, nursing and midwifery leaders, clinicians and regulatory authorities. The original working group comprised of experts from Local Heath Districts and Specialty Networks. The guide was focus tested with nurses and midwives across the system and this has assisted in preparing a resource that is relevant to every clinician providing nursing or midwifery care in the NSW Health system today. All of those consulted, generously gave of their time and expertise. We would like to express our gratitude to all those involved who have made this Superguide possible.

The initial development of The Superguide: A Supervision Continuum for Nurses and Midwives was overseen by a reference group from the Local Health Districts and Specialty Networks. The members were:

Ms Sally Auld, Colorectal Care Coordinator - Clinical Nurse Consultant - Royal Prince Alfred Hospital, Sydney Local Health District
Ms Susan Brazil, Nurse Manager, Nursing and Midwifery Services - James Fletcher Campus, Hunter New England Local Health District
Ms Pamela Bloomfield, Learning and Teaching Coordinator - Health Education and Training Institute
Ms Deborah Burke, Nurse Educator Mental Health - Centre for Education and Workforce Development, Sydney and South Western Sydney Local Health District
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Ms Michele Corkhill, Nurse Unit Manager, Medical 2, Coronary Care Unit, Wyong Hospital, Central Coast Local Health District
Ms Kelly Dart, Clinical Nurse Educator, Broken Hill Health Service, Far West Local Health District
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Ms Deborah Goglis, Nurse Manager - Clinical Leadership, Nurse Manager - Centre for Training and Development, Northern Sydney Central Coast Local Health District
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Mr Jon Magill, Acting Deputy Director of Nursing, Medicine and Critical Care, Nursing Administration, North Coast Local Health District
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Mr Ben Short, Nurse Educator - Forensic Mental Health, the Forensic Hospital, Justice and Forensic Mental Health Network
Ms Jenny Tyrrell, Manager, Nursing Development and Capability - Murrumbidgee Local Health District
Ms Jennifer Wannan, Manager - Training and Support Unit for Aboriginal Mothers, Babies and Children, Health Education and Training Institute - Rural and Remote Portfolio

Subsequent to the work of the reference group, and in a process of consultation and collaboration, there was the opportunity to consult with other industry, editorial and writing experts and the resource was refined to reflect the broader consultation. A small expert group was convened to guide this process, develop the scenarios, videos and the toolkit. These members were:

Shannon Cleary, Registered Nurse
Helen Eccles, Director of Nursing and Midwifery
Sue Harvey, Clinical Nurse Consultant
Paul Spurr, Clinical Supervision Consultancy

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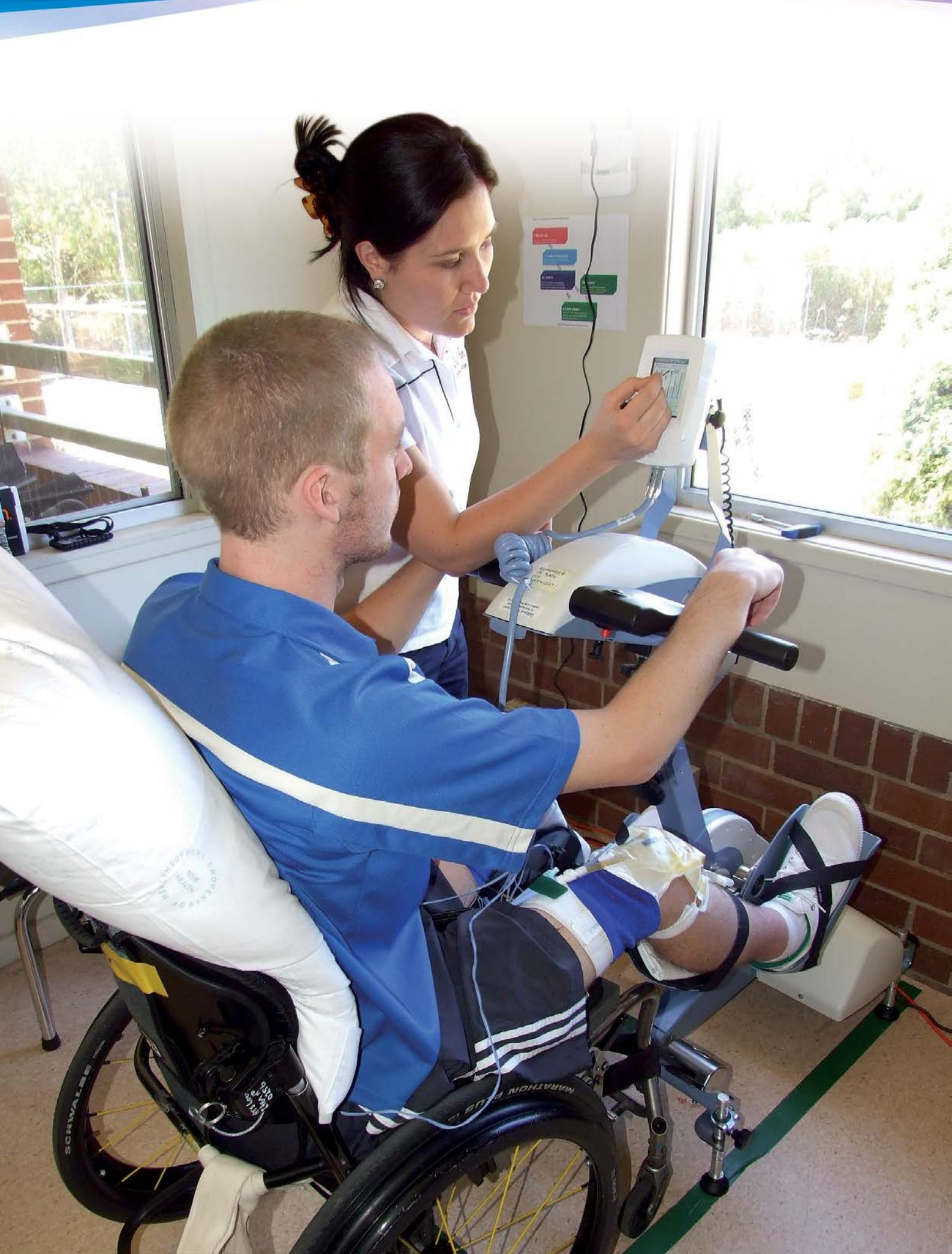
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SECTION 1
Overview

INTRODUCTION

Supervision is essential for the provision of safe person-centred health care, and this is reflected throughout the guide. While inadequate supervision has been a contributing factor in critical incidents resulting in poor patient outcomes, it is known that effective supervision reduces errors and improves the quality of patient care[1]. Supervision is an integral component of nursing and midwifery training, at all levels of professional practice.

Close supervision of clinical practice is required during the clinical placement of nursing or midwifery students, and during the transition of new graduates into the clinical setting. In addition, it is recognised that experienced staff commencing in a different setting also require supervisory support.

Experienced nurses and midwives can benefit from supervision to progress in their careers, and fulfil their responsibility to contribute to the professional development of their colleagues. Health professionals who have access to supervision report improved job satisfaction, which can lead to improved staff retention rates.[2]

The following key standards and codes define and underpin the scope of practice, and supervision of nurses and midwives in Australia:

- National Safety and Quality Health Service Standards[3]
- National Competency Standards for the Enrolled Nurse[4]
- National Competency Standards for the Registered Nurse[5]
- National Competency Standards for the Nurse Practitioner[6]
- National Competency Standards for the Midwife[7]
- Code of Professional Conduct for Nurses in Australia[8]
- Code of Professional Conduct for Midwives in Australia[9]
- Code of Ethics for Nurses in Australia[10]
- Code of Ethics for Midwives in Australia[11]

Aim of the Guide

The aim of The Superguide: A Supervision Continuum for Nurses and Midwives is to provide clear and accessible information for nurses and midwives about different types of supervision.

Objectives of the Guide

The objectives are to:

- be a useful and quick reference guide for nurses and midwives in NSW in a variety of settings
- augment NSW Ministry of Health and Local Health District policies, national professional competency standards, and national quality and safety standards
- define the different types of supervision available to support nurses and midwives
- guide the implementation of different types of supervision
- provide examples of supervision scenarios and questions for reflection
- connect information with a tool kit including scenarios, learning tools and links.

What is supervision?

In the context of this guide, the term supervision applies to a range of processes undertaken by nurses and midwives, as they provide or participate in supervision of professional practice. Reflection is a central component of all types of supervision, and is essential for improvements to patient safety and care.

The types of supervision described in this guide are defined in more detail in each section/subsection. Different types of supervision occur at all stages of professional development, and are not limited to less experienced staff. Supervision is required for the knowledge and skill acquisition at all levels of clinical competence, from Novice, Advanced Beginner, Competent, Proficient, to Expert.[12]

A range of supervision types can be utilised throughout the professional development of nurses and midwives. An individualised approach is preferable depending on need, but the importance of supervision is common to all health care providers. Supervision continues into the domain of the experienced practitioner who will benefit from engaging in a level and type of supervision appropriate to their professional development needs.

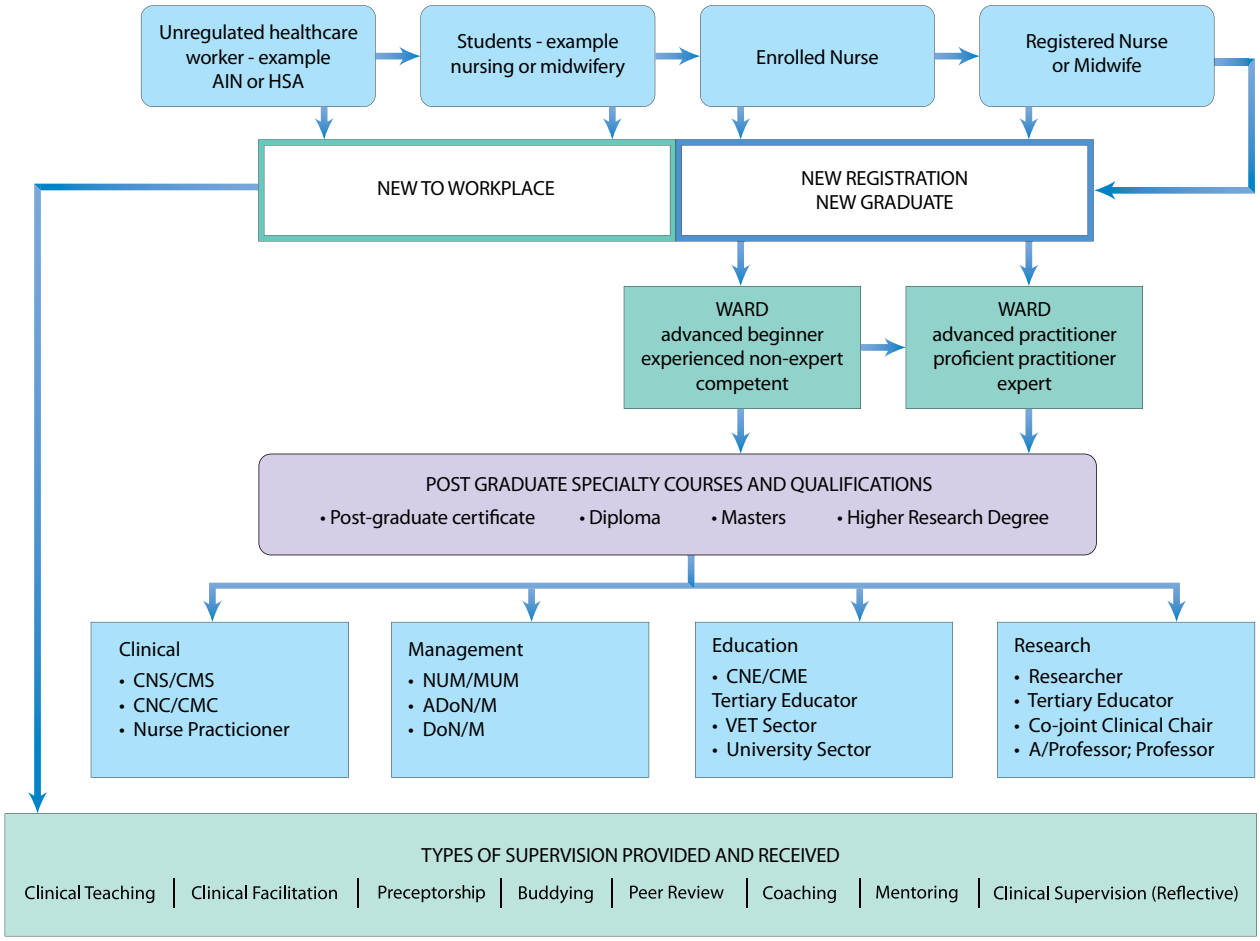
The topics covered include:

- Point of Care
  - Clinical teaching
  - Clinical facilitation
  - Preceptorship
  - Buddying
- Facilitated Professional Development
  - Peer review
  - Coaching
  - Mentoring
- Reflective Clinical Supervision

This resource provides an exciting opportunity for all nurses and midwives to discuss, develop and enhance their workplaces and patient care by embedding a culture of lifelong learning and reflection.

The flowchart below depicts the types of supervision which may be utilised throughout the career of nurses and midwives and healthcare workers.

Types of supervision and the professional development journey



The Supervision Continuum

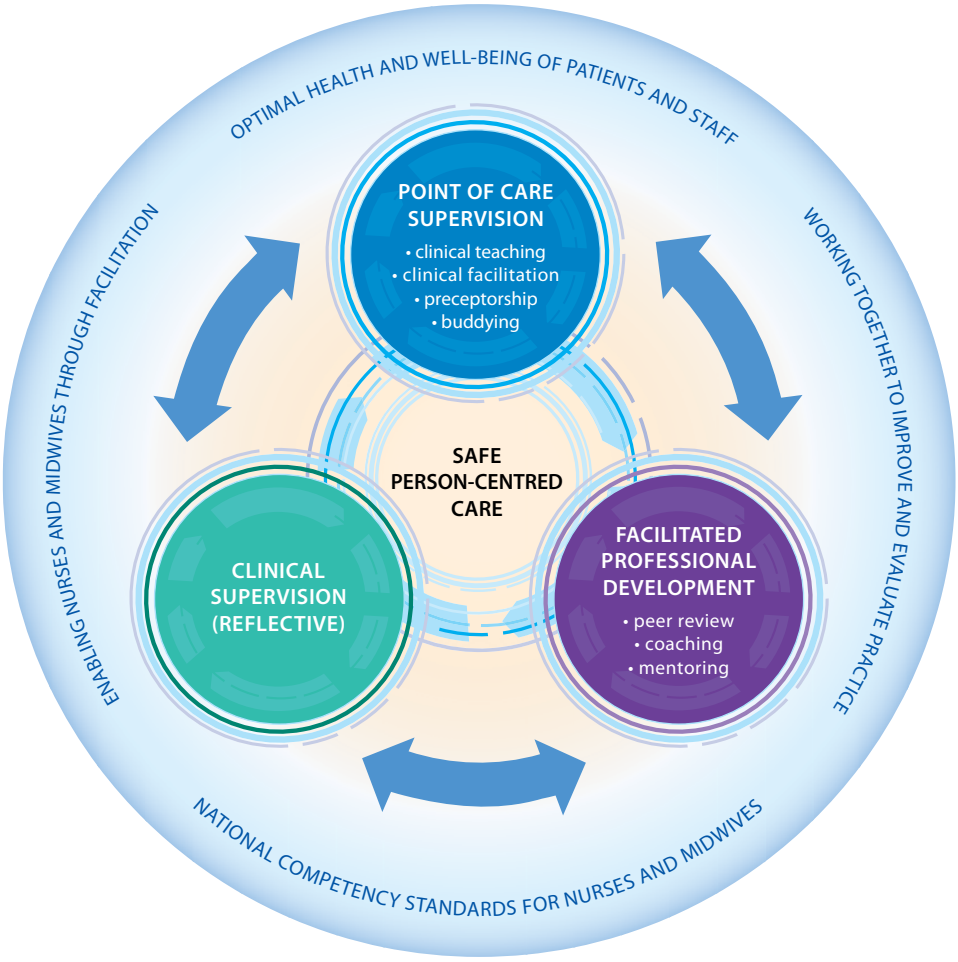
The different types of supervision found in the types of supervision and the professional development journey flowchart (on the previous page) form the central components of this guide.

There may be some overlap in the types of supervision, and how it is provided in nursing and midwifery practice.

A range of clinical services occur in acute settings including inpatient services for children and adults, midwifery services, drug and alcohol services, mental health services and aged care services. In addition, nurses and midwives also work in community-based services, both in metropolitan and rural locations. The setting and the availability of staff, often determines how different types of supervision can be provided.

The supervision framework for nurses and midwives below represents the various types of supervision presented in this guide.

Supervision framework for nurses and midwives



Structure of The Superguide: A Supervision Continuum for Nurses and Midwives

The three main sections of the guide link directly to the supervision framework for nurses and midwives and are easily found by following the colour-coding. Each section follows a similar format, and the What/Why/When/How questions are addressed for each type of supervision.

In order to provide concrete examples of supervision, the following sections also include an extended scenario and questions.

Point of Care:

- Clinical teaching scenario – Change of central line dressing

Facilitated Professional Development:

- Coaching scenario – Change of patient status
- Mentoring scenario – New Nursing Unit Manager

Clinical Supervision (Reflective):

- Individual clinical supervision scenario – Cardiac arrest

Types of supervision for nurses and midwives

	POINT OF CARE SUPERVISION			
	CLINICAL TEACHING	CLINICAL FACILITATION	PRECEPTORSHIP	BUDDYING
Description	Education of specific clinical and non-clinical skills	Supervision and support of nursing and midwifery students during clinical placement. The supervisior educates the nurse or midwife in the use of practice development tools	Clinical support for new staff during the transition to the new work environment	Welcome and orientation to the new work environment
Delivery Method	Opportunistic informal/ formal Individuals or group	Informal/formal Individual or group	Informal/formal Individual	Informal Individual
Duration	Short term episodic/ planned	Short-medium term	Short term	Short term Commencing first day
Feedback Process	Feedback to the learner, and NUM/MUM as required	Ability to reflect on practice. Doing for others to enabling others Feedback can be to student and may include an education provider	Feedback to the preceptee, and NUM/ MUM	Feedback to new staff member and NUM/ MUM
Intended outcomes	Increased knowledge, clinical skills, and application of theory to practice Safe clinical practice Competency attainment	Safe patient care during student learning Application of skills and knowledge to practice Feedback, guidance and encouragement to continue development Working towards competency attainment	Increased knowledge, clinical skills, and application of theory to practice Safe clinical practice and supported transition to work environment Competency attainment	Quicker integration into the work environment Interactions with NUM/MUM are more focused on key areas Increased opportunity for connection with other staff
Examples	Teaching opportunities. - Direct patient care - At clinical handover - During ward rounds - Education sessions	Observation of direct patient care and in-direct care by RN/RM in accordance with student's level of training and experience Case discussion/review Debriefing	Orientation to clinical procedures and processes Support to achieve learning goals Observation of competency and transition	Orientation to physical work environment New staff member able to ask questions freely

	FACILITATED PROFESSIONAL DEVELOPMENT			CLINICAL SUPERVISION (Reflective)
	PEER REVIEW	COACHING	MENTORING	CLINICAL SUPERVISION
	Evaluation of care by colleague of a similar level of experience and position	Development of specific skills and knowledge to attain identified goal	Senior professional shares knowledge and expertise to nurture professional growth	Reflection on work and professional issues
	Informal/formal Individual or group	Informal/formal Individual or group	Informal/formal Individual – instigated by the mentor	Formal/structured Individual or group
	Short- medium term (at regular intervals or in response to need)	Short term	Long term (flexible according to need/ availability)	Long term
	Feedback to peer/s NUM/MUM awareness of peer review process	Feedback to coachee May include feedback to manager	Feedback to mentee Manager may be informed by mentee	Feedback to supervisee/s
	Quality and safe care Performance accountability and enhancement Professional Development Measuring practice against professional standards of practice	Focused support in the attainment of goals Empowering and enabling Improved performance and well being Development of future leaders	Extended support in the attainment of goals Further development of capacity and skills Sustained development of leaders	Improved clinical practice and professional development Exploring new ways of working and/ or dealing with difficult situations More reflective, vibrant professional staff members
	Review of medication errors, falls Auditing of files to improve documentation Case Review Root cause analysis	Leadership development Clinical leadership programmes, including 'Take the Lead' (for managers)	Mentoring programmes Development of managers and clinical leaders	Individual or group supervision with a trained supervisor Peer supervision

SECTION 2

Point of Care Supervision

CLINICAL TEACHING

CLINICAL FACILITATION

PRECEPTORSHIP

BUDDYING

CLINICAL TEACHING

Clinical teaching is the main point of care supervision activity. It occurs in all areas of nursing and midwifery practice, in both acute and community based settings. The provision of quality health care is influenced by the way staff interact with patients and carers, and how knowledge and skills are applied.

what

WHAT is clinical teaching?

Clinical teaching is the process of developing and sharing professional knowledge. It is the opportunity for an experienced clinician to transfer knowledge and skills to one who has less understanding in that clinical area. It is a key responsibility of every nurse and midwife throughout their professional lives. Clinical teaching includes, but is not limited to:

- clinical skills for direct patient care
- non-clinical skills for indirect patient care.

why

WHY is clinical teaching important?

Effective clinical teaching is essential for the ongoing provision of safe, optimal health care and the professional development of nurses and midwives. Involvement in clinical teaching is important for nurses and midwives with all levels of experience. This could be either in the role of learner or teacher or dependent on the situation and stage of professional development.

Clinical teaching assists and supports:

- students from tertiary education facilities undertaking a clinical placement as they integrate knowledge and skills
- new staff (re-entry or on a new graduate programme) as they learn additional knowledge and skills relevant to a clinical setting
- nurses and midwives entering a new workplace setting/new role or both
- continued professional development opportunities
- life-long learning for all nurses and midwives.

Clinical teaching forms a part of the core national competency standards by which performance is assessed against for registration for nurses and midwives.

when

WHEN can clinical teaching be provided?

Clinical teaching can be either formal in a classroom environment (for example, a planned education session) or informal (for example, case discussion following a change of patient status). The teaching may occur with a nurse or midwife on an individual basis, or a number of team members may participate.

Clinical teaching opportunities may occur:

- during direct patient care
- at clinical handover
- during ward rounds and other interprofessional contact
- at case discussion/case review and case presentations
- when implementing practice change
- through formal ward/unit education sessions
- at semi-formal in-service sessions
- during simulation sessions
- at every opportunity.

HOW should clinical teaching be provided?

how

Clinical teaching should be provided through a collaborative and partnership approach, with a focus on supporting and encouraging the learner.

Role of the teacher in the clinical setting

The role of the teacher is to act as a valuable clinical resource person who can provide learners with educational support and facilitate best practice in the clinical setting. Knowledge sharing is the responsibility of every nurse and midwife caring for patients regardless of the setting.

Clinical teachers:

- make available appropriate resources
- support learners during the process of developing a skill and/or when learners have difficulty understanding the required level of knowledge
- are available, approachable, enthusiastic and empathetic role models
- need to be respectful of competency levels for specific tasks
- are sufficiently engaged and vigilant to support staff when help is required (patient safety may be at risk when learners do not recognise the limitations of their knowledge and skills)
- recognise the limits of their own knowledge and refer learners to other sources
- are organised and current with evidence-based practice
- understand that knowledge and skills can vary depending on the setting, the competency and skills of the learner.

Learner role

Learners:

- are actively involved in the entire educational process
- use reflection to identify their own level of professional competence
- openly communicate about issues and successes, and seek support from more experienced professionals when required
- are accountable for the care they provide according to their scope of practice and level of experience
- apply theoretical knowledge while learning the variety of skills they need to provide safe and ethical patient-centred care.

Clinical teaching of clinical skills during direct patient care

Clinical teaching in the presence of patients can be powerful and effective. Theoretical knowledge becomes practical - in the real world, with real patients. When providing clinical teaching at the point of care, or in the presence of patients, there are three or more parties involved – patient, learner, clinical teacher.

Preparation for clinical teaching during direct patient care

It is essential for the clinical teacher to prepare both the learner and patient for the teaching session. Patients who could provide a good learning opportunity may be identified from the clinical handover.

Most workplace learning happens informally as the opportunity arises. Opportunistic learning is almost always unstructured, experiential and spontaneous in nature. Every nurse and midwife should observe for and take advantage of opportunities to provide clinical teaching.

Guidance on teaching new skills is provided in the box below.

Four steps to effectively teach new skills[13]

1. **Demonstrate:** demonstrate the skill at normal speed without talking
2. **Deconstruct:** demonstrate the skill while describing the steps
3. **Comprehend:** demonstrate the skill while the learner describes the steps
4. **Perform:** the learner demonstrates the skill and describes the steps while the teacher watches

Adaption, Walker & Peyton (1996)

When preparing to teach in the presence of patients, the following principles should be followed to maximise patient safety and comfort.

- Obtain consent from the patient in private (where possible) before the clinical teaching session commences.
- Introduce all those involved in the clinical teaching session.
- Provide a clear explanation of all procedures, discussions and communications involved in the clinical teaching session, so that the patient can understand.
- Thank the patient for their consent to be involved in a clinical teaching session and invite questions.

Patient safety, comfort, privacy and confidentiality are paramount and should be monitored at all times. If during a clinical teaching session, there is a critical incident, the patient withdraws their consent or patient safety is at risk, the session is immediately discontinued. The patient is reassured and the clinical teaching session reviewed in a constructive and non-confrontational way. This includes debriefing and the opportunity for further reflection. If learners require additional support, simple interventions can be effective if introduced early. Nurses and midwives are encouraged to seek support and guidance from their line manager, other senior colleagues and/or support networks available within the health service.

Clinical teaching at clinical handover

Clinical handover is the transfer of professional responsibility and accountability for a patient, or group of patients, to another person or professional group on a temporary or permanent basis,[3] and is vital for the provision of safe and effective clinical care. Clinical handover should communicate holistic patient care. An example of a structured communication tool to assist with clinical handovers is ISBAR (See Appendix 6).

Clinical handover can occur in a variety of ways and can be dependent on the:

- situation of handover. For example, at a shift change; transfer of patients between wards and units
- method of handover. For example, face-to-face; telephone
- venue where handover takes place. For example at the patient's bedside.

Clinical teachers and supervisors should frequently discuss principles of effective clinical handover to build the skills of nurses and midwives and support the safe transfer of patients. The use of best practice principles for the safe and effective handover of patients occurs in accordance with National Safety and Quality Health Service Standards[3] and national and state policy directives and guidelines.

A well-structured handover provides an excellent learning experience that integrates communication, professionalism and clinical management. During handover, staff members learn techniques of clinical description and case management. It is also an important team-building exercise and can provide opportunities for the patient to have input into their care.

Clinical teaching via inter-professional learning

Inter-professional learning is a relatively new term to describe occasions where two or more health professionals learn with, from and about each other, to improve collaboration and the quality of patient care, yet respecting the distinct contribution that each discipline offers.[14]

In the acute setting, ward rounds are an excellent opportunity for inter-professional learning, as health professionals come together to jointly review the patient's progress. There can be a number of representatives from the various allied health professions along with the medical, nursing and/or midwifery team present. During ward rounds, staff should include the patient where possible and obtain a more comprehensive medical history. Discussions during ward rounds can include patient progress, pathology and test results, and the patient's response to care including the carer's perspective if required. A key outcome for inter-professional learning is for the main health professional caring for the patient to better understand the details and reasons behind the ongoing management plan. Ward rounds are used for discharge/transfer of care planning with the interdisciplinary team, patients and carers to optimise outcomes and or transfer to non-acute care.

Nurses and midwives may miss ward rounds because of the timing with other patient care requirements, it is important to view the ward round as a potential learning opportunity. Nurses and midwives often have a special rapport with the patient and their carers, due to the nature of their work and the amount of time they spend with them during each shift. The mutually respectful relationship between the nurse or midwife and their patient, and the in-depth knowledge that they may have about the patient is important to share with other disciplines, so that all clinicians have current information to collaborate with the patient about their ongoing care and management.

Clinical teaching of non-clinical skills

A productive team member in a discipline specific or multidisciplinary team also completes administrative tasks, projects and quality improvement activities, in addition to clinical practice requirements.

Essential non-clinical skills for the new nurse and midwife include managing workloads, inter-professional practice, team dynamics and coping with the demands of the rapidly changing health care environment. A workload that is not prioritised effectively may leave a nurse or midwife feeling overwhelmed, and contribute to essential tasks, necessary for safe patient care, not being completed.

Clinical teachers can assist new staff members to develop time management and prioritisation skills by guiding them to use some of the following strategies.

- Prioritise patients in order of need.
- Complete all care activities, including documentation, for a particular situation before commencing any other activity.
- Awareness and response to changing needs of care activities and other team members.
- Request assistance from another team member when it is needed.

The teaching of clinical and non-clinical skills is enhanced by the use of guided questioning (see box below).

Teaching by guided questioning[15]

Teaching by guided questioning encourages independent thinking and problem solving. It allows the learner to test options, analyse risk and consider limitations and innovations. These are some examples of guided questions:

- What approach are you taking here and why?
- Can you explain the steps of the task / treatment / intervention and why you are doing them that way?
- What outcomes do you want and how can they be achieved?
- What is your action plan if this approach doesn't work?
- What values, attitudes, knowledge and/or skills are being challenged in this situation?
- How would you approach the situation next time?

TOP TIPS FOR CLINICAL TEACHING

- ✓ Don't forget the fundamentals - remember to demonstrate hygiene and infection control measures, patient communication, consent and introductions as key steps.
- ✓ Demonstrate - make sure the learner can clearly see what you are doing. Where the situation allows, combine both the supervisor demonstrating the skill and the learner performing it.
- ✓ Integrate theory and practice - explain the logic and the evidence behind the skills that you are demonstrating to develop clinical reasoning.
- ✓ Be opportunistic - share what you can, as best you can. Draw the nurse or midwife to one key aspect of the task.
- ✓ Teach using guided questions - don't teach everything at once, particularly when you are demonstrating more complex skills or procedures, you do not need to teach every step every time. Find out what the learner already knows, then review the unknown steps in more detail.
- ✓ Encourage independent learning and invite staff to set the agenda - adult learners should be involved in decisions about the direction and content of learning. Your ultimate objective as a supervisor is to foster the ability for self-directed lifelong learning.
- ✓ Provide opportunities to practice skills - make time and space available for the learner to practice. Break procedures into steps, provide direction and share patient care. Repetition is the key to teaching new skills, with a focus on building competency.
- ✓ Use collaborative problem solving - give learners a clinical problem and work with them towards a solution.
- ✓ Give timely, specific and constructive feedback - always give feedback in an appropriate environment. Invite feedback from the learner to improve your teaching techniques.
- ✓ Provide appropriate learning resources - know what resources are available to help staff develop better understanding.

Quote from Florence Nightingale (1860)[16]:

"The most important practical lesson that can be given to nurses is to teach them what to observe. …."

Point of care - Scenario 1
(Clinical teaching of a procedure at the bedside)

scenario

Karen is the Clinical Nurse Educator in a high dependency unit. She has been involved in educating Rob, a new member of staff, and helping him make the transition back into the workplace. Rob has previous experience working in high dependency, but has spent the last four years away from nursing.

During a morning shift, Rob is required to change the central line dressing on a number of his patients. He approaches Jo, a senior Registered Nurse, and asks if she will provide some clinical teaching. Jo agrees, but tells Rob "it will have to be quick, I'm very busy." She instructs Rob to wait at the bedside while she assembles the equipment. She returns and begins washing her hands and setting up the dressing trolley, ignoring both Rob and the patient. She begins the procedure with no word of explanation to the patient. The curtains are open and the patient's chest is partially exposed to access the central line site. The patient looks confused and upset. Jo speaks directly to Rob, ignoring the patient. "Now watch, I'll show you how to do this once, and the rest you should be able to do on you own." She carries out the procedure, occasionally describing her actions, but mostly using medical terminology that the patient cannot understand. Rob attempts to ask questions, but receives only brief responses. He gets the sense that Jo does not appreciate being interrupted. When Jo is finished, she looks to Rob and asks "Are we'all good'now? If you have any problems, talk to one of the other girls, I'm really busy." She walks away, leaving Rob and the patient looking slightly bewildered.

Karen is passing by the bedspace soon after, and finds Rob looking anxious. She observes that Rob is preparing a trolley for a procedure. She asks Rob if he would like any help. Rob explains the situation. In the interests of patient safety, it is unit policy for new staff to complete a learning package and formal assessment prior to being able to perform a central line dressing unsupervised. Karen decides to use this opportunity to review the learning package and practice some on the spot clinical teaching at the bedside with Rob.

Karen asks Rob if he has performed a dressing to a central line in the past, and if so, how was it done. Rob states that he has, but that it was "a long time ago." He is keen to refresh his knowledge and receive some education about the procedure and rationale. Rob states that he has recently reviewed the literature in the learning package related to this type of dressing in order to familiarise himself with the unit's practice.

Rob's learning goal is to be able to safely demonstrate correct procedure for changing a central line dressing. Karen discusses her expectations for the morning's clinical teaching and outlines the plan of action. Rob will be able to observe as she performs a central line dressing, providing him with a rationale for each step. She encourages Rob to ask questions throughout the procedure. She will then supervise as Rob performs a dressing change, provided she feels he has understood the clinical teaching and is safe to carry out the task. Karen will assess Rob using the assessment tool in the learning package.

The results of the assessment will be documented and conveyed to the Nursing Unit Manager. Guided questioning will be used throughout the process, to assess Rob's understanding and critical thinking skills. Karen will give feedback on Rob's performance as he carries out the task, and at the conclusion of the learning session.

Karen supervises Rob as he assembles the necessary equipment. They approach the bedside of Mrs M. Karen introduces herself and obtains her consent for the procedure and for the clinical teaching. Karen's priority is to ensure that patient safety, comfort, dignity and privacy are maintained throughout the procedure/teaching. She assures Mrs M that all aspects of her care will remain confidential.

Karen washes her hands and performs the dressing change, ensuring all communication involved in the process is explained so that the patient is able to understand. Rob listens and asks questions to clarify information and expand his current knowledge.

Karen then asks Rob to discuss the steps of the task, providing a rationale at various stages of the process. Karen uses guided questioning to encourage independent thinking and problem solving. For example, 'What approach are you taking here and why? What are the possible complications? How would you recognise/prevent/respond to these situations? How would you approach this next time?'

Karen is satisfied with Rob's knowledge and critical thinking/problem solving skills and they move on to the second patient. Rob is about to begin the procedure when Karen interrupts. She reminds Rob to introduce himself to the patient, explain the procedure and obtain consent before beginning the task. She identifies that Rob has forgotten to position the patient correctly prior to donning his sterile gloves, and encourages him to take time before commencing the task to ensure that all the necessary preparation has been carried out. Rob changes the dressing following the correct procedure and is able to describe each step as he approaches it, allowing Karen to ensure that he is acting safely.

At the end of the procedure, they thank the patient and move away from the bedside to discuss Rob's performance in more detail. Karen commends him on his success, giving examples of aspects of the task that he performed well. "You did a really good job Rob. Your hand washing and aseptic technique are correct. You understood the steps of the procedure and performed them correctly. You described to me the complications that can occur and demonstrated good critical thinking when asked how you would respond to these situations. It is great that you asked lots of questions. It shows me that you are able to recognise the limitations of your practice and can identify when to ask for help.

The two areas that you need to work on are preparation and communication. It's important to communicate with the patient and prepare your workspace before you begin the task. Take a moment to plan what you are about to do and run through the process we have just completed in your head before you start, to check that you have covered everything and can move ahead confidently."

Karen asks if Rob has any questions. She provides Rob with a copy of the completed assessment form and refers him to online learning material and unit policies he can access for further reading.

SCENARIO QUESTIONS

1. Why would point of care clinical teaching be helpful for Rob?
2. How did Karen establish the clinical teaching relationship with Rob?
3. What skills does Karen use as a clinical teacher to empower and enable Rob?
4. What other strategies do Rob and Karen use to assist in Rob's skill development?
5. Where and how are you provided with support for your clinical skills development?
6. What is your experience of point of care clinical teaching?

CLINICAL FACILITATION

Clinical facilitation is the term used to define the nurse or midwife with professional training in facilitation utilising a practice development system approach.

what

WHAT is clinical facilitation?

Facilitation is a technique where one person makes things easier for others.[17] The skilled supervisor voluntarily educates the volunteer nurse or midwife in the use of practice development tools.

Outcomes of clinical facilitation include:

- participants become active, enthusiastic, self-directed learners
- the facilitator can become a co-learner
- the facilitator and participants start to genuinely collaborate as equals.

why

WHY is clinical facilitation important?

Effective clinical facilitation can aid in the development of professional expertise through quality improvement in standards of patient care and help developing nurses and midwives to critically review their work practices, learning from their own analysis.

Clinical facilitation can be used to:

- provide help and support to achieve specific goals
- enable people to analyse, reflect and change their attitudes, behaviours and work methods.[18]

when

WHEN is clinical facilitation provided?

The role of the facilitator exists on a continuum from doing for others to enabling others.

'Doing for others'[18] is characterised by episodic contact, practical assistance, being task-driven, doing tasks for people, and do as I tell approaches.

'Enabling others'[18] is characterised by ongoing partnerships, which are developmental in nature by focusing on transforming people, practices and culture, and an adult learning approach.

Like any complex skill, developing facilitation requires considerable time, interest, practice and guidance. There are no short cuts. Simply reading about facilitation will not be enough to implement it. It is important to engage in a variety of learning strategies that will build a scaffold for ongoing development of facilitation knowledge, skills and attributes.

Successful clinical facilitation

- Include facilitation in your personal development plan, and negotiate with your manager and colleagues to engage in work-based learning around facilitation.
- Get involved in individual or group-based active learning processes. For example clinical supervision, mentoring, coaching, critical companionship.
- Model the skills and attributes of skillful facilitators.
- Practice your facilitation skills and ask for feedback.
- Reflect on your facilitation practice. For example through reflection logs.
- Participate in practice development. See Appendix 7 - for self assessment tool example.
- Read about facilitation, learning and development, and practice development.

HOW should clinical facilitation be provided?

how

Nurses and midwives who choose to work in other specialties may require initial clinical facilitation to support development of practice during transition. Another important part of clinical facilitation includes the supervision and support of nursing and midwifery students during clinical placement. The clinical facilitator may be employed by the tertiary education facility, the health care facility or by a training organisation.

Clinical facilitation of nursing and midwifery students during clinical placement should be provided in a way that maintains patient safety and supports the application of knowledge to practice. Students require varying levels of supervision and support to learn new skills, and integrate knowledge during clinical placement. Supervision provided through clinical facilitation will be defined by the individual clinical setting and assessed by registered nurses and midwives.

Student clinical facilitation

- Provides opportunities for students to develop the competencies expected of them as a nurse or midwife.
- Assists learning in the integration of theoretical knowledge into the dynamic experience of clinical practice.

The level of supervision required is dependent upon a range of factors such as:

- level of student - first year students require more supervision than students ready to graduate
- individual student ability - students may have previous experience in health care settings and workplaces, while others have limited experiences. For example, third year registered nursing students may have experience working as an Assistant in Nursing
- the nature of health care work - students working with patients that are clinically unstable will require more direct supervision.

Students are encouraged to reflect on their experiences through activities such as journaling. Timely and effective debriefing about the clinical experience, is also an important strategy to manage the personal stress that can emerge during clinical practice.

Clinical facilitator role

- Encourage students to be proactive in identifying and maximising valuable learning opportunities across a range of areas as well as working within the nursing or midwifery team.
- Awareness of any clinical and/or non-clinical opportunities for student learning.

Student role

- Identify their learning objectives.
- Develop own theoretical knowledge and skills in a way that is relevant to clinical practice.
- Obtain feedback on progress.
- Work towards completing competency assessments.

TOP TIPS FOR CLINICAL FACILITATION

- ✓ Encourage students to use theory to understand their clinical experience.
- ✓ Challenge students to link clinical events and decisions with theory.
- ✓ Supervise students during learning opportunities.
- ✓ Encourage students to engage in new learning opportunities.
- ✓ Assist students to plan patient care.
- ✓ Ensure the patient has given consent prior to the student providing care.
- ✓ Ensure students become aware of ward policies and procedures.
- ✓ Ensure the patient's privacy and rights are protected.
- ✓ Conduct briefing and debriefing sessions as required.
- ✓ Provide students with feedback on their progress acquiring and integrating new skills.
- ✓ Encourage students to reflect on their learning and observations and provide feedback to their clinical facilitator.

PRECEPTORSHIP

Preceptorship is recognised as an important component of providing support to nurses and midwives as they transition into a new work environment. Although preceptorship has different meanings, it is intrinsic to the supervision of new nurses and midwives. The fundamental goal of preceptorship is to provide safety for patients and staff at a time when an increased level of supervision is required. The integration and supervision of students, new graduates and those new to a ward/unit is the responsibility of all team members, and is not limited to any one designated preceptor.

The information provided in this sub-section can be augmented by referring to other types of supervision found in the guide. Some areas which may overlap are found in the sub-sections, Buddying and Clinical Facilitation.

what

WHAT is preceptorship?

Preceptorship is a formal agreement, and can be defined as:

"…a relationship constructed to link seasoned, experienced nurses (preceptors) with students, new graduate nurses, or new orientees (preceptees) to facilitate their orientation and integration into their new roles and responsibilities in the professional practice environment of care". [19]

The main functions of preceptorship are to provide orientation and support, during the process of teaching and sharing of clinical expertise.[20] Preceptorship is more than a condensed orientation programme or a short-term strategy to retain staff. Initial confirmation and/or assessment of knowledge and skills against the position description and professional competency requirements of the preceptee are essential. Competencies related to the specific ward/unit also need to be identified and confirmed.[19] Preceptorship is not intended to facilitate career development in the long term, this is known as mentoring.

why

WHY is preceptorship important?

The beginning of a nurse or midwife's professional career is a challenging time, and first experiences can be crucial. The adjustment of a new nurse or midwife into a clinical environment has been described by Kramer (1974) as 'reality shock,'[21] and the support and retention of staff through preceptorship is central to the ongoing provision of quality health care. Preceptorship has been positively evaluated, and it helps preceptees "mature into strong practicing professionals within new or different professional practice environments". [19]

The benefits for patients and carers, preceptee, preceptor, and health organisations include:

- enhanced patient safety, care and experience
- increased levels of competence and skill
- improved recruitment and retention
- reduced sick leave
- higher levels of work satisfaction and morale
- increased preceptee confidence in own abilities.

Preceptorship is an important component of succession planning as staff are more likely to remain in the workforce where they are supported, and a positive work culture exists.

WHEN is preceptorship provided?

when

Preceptorship is provided until the conclusion of the agreement. The preceptee should be confident and competent with the range of knowledge, skills and attitudes required for their role and level of experience.

Situations where preceptorship is utilised in the transition process include:

- nursing and midwifery students on clinical placement
- new staff with beginning level competence after completing a pre-registration course and entering the workforce for the first time
- staff from specialist post-graduate courses
- staff moving to new practice settings.

The length of the relationship is approximately 3-4 months[20] and depends on a number of factors including the experience of the preceptee in the specialty area, and the level and range of prior experience.

HOW should preceptorship be provided?

how

Preceptorship should be provided by a suitable preceptor, or team of preceptors. In the team approach, the new staff member does not rely on only one member of the team to provide support and guidance. This allows greater flexibility with rostering, especially when required at short notice.

It is important for managers to follow the selection criteria and processes relevant to the practice setting. Preceptors usually require at least twelve months or equivalent experience within the same or similar specialty area.[20]

The preceptor role

As preceptorship is crucial for the integration of new staff, preceptors should have access to a partnership-based and targeted training course for preceptors[22] and have recognised personal qualities and professional skills.

The content of preceptor training courses may include:

- clinical teaching strategies
- adult learning theories
- strategies for evaluating students.[23]

A preceptor encourages, teaches and serves as a good role model.[24] The role of the preceptor is complex and includes being a competent practitioner, teacher, communicator, assessor, and problem solver. The preceptor agrees to work in partnership with a new registered practitioner or colleague to help and support them as they learn and adapt to their new role.

Preceptors plan and prepare to support a preceptee by:

- staying in contact with the ward/unit manager about employment of new staff. For example, be aware of new employee start dates, and staff transferring from other areas
- being aware of the previous experience of the new employee before they start
- ensuring the preceptee is rostered on the same shifts as the preceptor for a minimum of one to two weeks
- allocating the preceptee to another preceptor or working in partnership with other preceptors in a coordinated approach
- working in partnership with the unit manager to ensure shifts allocated are appropriate to the learning needs of the preceptee and of the ward/unit. For example, after hours shifts may not provide learning experiences or opportunities
- communicating with unit staff where the preceptor will be providing support to the preceptee, that is the preceptor should not be disturbed from this important role unless required for patient care
- checking the unit orientation materials, and the availability of staff development programmes
- planning for the preceptee's orientation to the unit in collaboration with the manager
- providing access to HETI on line modules and how initial learning needs will be met
- reflecting on feedback from previous preceptorship experiences to improve the support provided.

The Preceptee Role

Preceptees are responsible for collaborating with their preceptor for the development of their learning goals.

It is also essential for preceptees to:

- take responsibility in being prepared to enter the clinical setting
- communicate effectively with the preceptor by asking questions
- request additional support or guidance when it is required.

Clear and open communication with the preceptor and other staff is vital, especially so the preceptor is aware of any problems and can arrange early support if it is needed.

TOP TIPS FOR PRECEPTORSHIP

- ✓ Share as much information as possible about the ward/unit.
- ✓ Discuss the ward/unit/organisation's formal and informal levels of operation and goals.
- ✓ Keep the preceptee's goals in mind and discuss performance expectations. Focus on solving problems and include the preceptee in your decision making process. Review the preceptee's objectives daily.
- ✓ Provide patient care according to established practice standards and act as a role model demonstrating attention to patient safety and quality patient care.
- ✓ Demonstrate skills in problem solving, decision making, priority setting, work delegation and work organisation. Demonstrate effective written and verbal communication skills.
- ✓ Give frequent, specific feedback to the preceptee. The preceptor should also expect feedback from the preceptee and ask for feedback if it is not offered.
- ✓ Allow the preceptee to set their pace and encourage accountability while undertaking a learning contract. Make suggestions for improving the preceptee's time management skills and setting priorities if time-frames need to be extended. Encourage preceptee to challenge and extend themself during the transition period.
- ✓ Reassure the preceptee that the preceptor, or a co-preceptor is available to provide support and guidance.
- ✓ Stay focused on the positive aspect of helping the preceptee. The thoughts and feelings of the preceptor and their response to any interaction/event can have a direct impact on the preceptee.
- ✓ Have a positive professional attitude. This helps minimise stress and anxiety of the preceptee so that learning can take place.
- ✓ Utilise strategies to minimise barriers to a successful preceptorship relationship.
- ✓ Maintain mature and effective working relationships with all members of the health care team. Effective interpersonal skills assist the integration of the preceptee into the team.

"The capacity to watch over and guard the well-being of others is an important gift, and one that is learned with great difficulty. For it is one thing to see the situation others are in, but it is quite another to care enough about them to want to help, and yet another to know what to do".[19]

"New nurses and nursing students bring fresh perspective to patient care settings including new knowledge or skills that can be extremely advantageous. The patient care setting can become newly infused with enthusiasm that can spread and expand among current staff.… and help provide optimism and positive feelings that are welcomed by any manager".[20]

BUDDYING

Buddying supports staff or students commencing in a new work environment. A buddy can provide encouragement and help to a new staff member, that results in greater workplace engagement. Additional information about support at this time is also discussed in the sub-sections, Preceptorship and Clinical Facilitation.

what

WHAT is buddying?

Buddying is a form of support provided to new staff members and should ideally commence on the first day in the workplace. It is usually undertaken by a skilled and effective team member who can partner well and be an informative resource person.

The right partnership between a buddy and new staff member may result in greater benefits for the organisation, because of the support provided.

why

WHY is buddying important?

Buddying is important because it assists new staff members to settle more quickly into their role, and become a valued and effective part of the nursing or midwifery team. Buddying provides support to new staff members by:

- providing a knowledgeable and skilled member of staff
- designating a clear and available contact person from amongst their peers
- introducing them to other team members, contributing to positive working relationships
- providing early opportunities for the new staff member to ask questions and clarification of organisational processes and tasks
- offering early assistance if the new staff member has particular needs that require consideration
- giving support during adjustment to processes particular to the ward/unit
- providing a positive role model
- focussing on key areas, rather than on less critical queries and background information for managers and new staff.

when

WHEN is buddying provided?

The new staff member is usually allocated a buddy by the Nursing Unit Manager or Midwifery Unit Manager, or their delegate. In some instances several experienced staff from the work area act as resource staff for new employees.

HOW should buddying be provided?

how

A buddy should be a staff member who is approachable, knowledgeable and available to the new staff member. Ideally, they are also a peer with whom the new member of staff feels comfortable to ask questions, due to their high level of communication and interpersonal skills.

The buddy is not the new staff member's manager, coach or mentor, and has no responsibility for performance review or formal training. The relationship between the buddy and the new staff member should be open, confidential, positive and supportive.

The buddy role

The buddying role may include:

- welcoming the new staff member to the ward/unit, and introducing them to other team members
- providing orientation to the physical layout of the workplace, policies and procedures
- regular informal catch-ups with the new staff member during the first few months of their employment
- informing the new staff member of the buddy role, contact details and other support staff and resources available.

TOP TIPS FOR BUDDYING

- ✓ Greet the new staff member warmly on their first day in the workplace.
- ✓ Introduce the new staff member to other team members.
- ✓ Orientate the new staff member to the physical environment, including amenities.
- ✓ Be a positive role model.
- ✓ Promote a positive workplace culture.
- ✓ Develop a trusting relationship with the new staff member.
- ✓ Be accessible.
- ✓ Provide constructive support.
- ✓ Demonstrate positive workplace attitude.


NSW HEALTH
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SECTION 3

Facilitated Professional Development

PEER REVIEW

COACHING

MENTORING

PEER REVIEW

In the clinical setting peer review can occur at the individual or team level, as well as through the provision of information to a committee formed for the purpose of monitoring and improving health systems and person-centred care.

what

WHAT is peer review?

Review of nursing and midwifery practice by a peer or peers aims to identify opportunities to improve patient care.[25] A peer reviewer can be defined as an individual practising in the same profession and having a level of expertise in the appropriate area. Peer review is differentiated from review by a manager, and is not used for performance management.

Examples of peer review include the auditing of files by peers to monitor and improve documentation skills and processes. Peer review can also monitor and address common issues such as falls and medication errors, or deviations from accepted professional standards.

why

WHY is peer review important?

Peer review encourages nurses and midwives to be active participants in monitoring and improving each other's practice and enhance patient safety and care quality. It requires nurses and midwives to be purposefully engaged in observing, evaluating and discussing their own work. Peer review requires a supportive and respectful environment, where aspects of care are examined, highlighting the positive aspects and reflecting on areas for improvement.

Peer review:

- helps to maintain standards of patient care
- reinforces the self-regulating nature of the nursing and midwifery professions
- has the potential to create a culture of safety
- can increase teamwork, creativity, transparency and a sense of ownership amongst nurses and midwives.

WHEN does peer review occur?

when

Peer review may be incorporated into a quality improvement plan and can occur at regular intervals or be undertaken at any time in response to concerns raised by team members. Examples of opportunities for peer review include:

- informal practice development at the ward or unit level. For example, during team meetings
- formal practice development at the ward or unit level
- professional standards review processes.

HOW is peer review provided?

how

The process of peer review is undertaken in accordance with its purpose, and whether it is an informal or formal review.

The peer reviewer role

For this to be an effective process the individual undertaking the review requires clear mechanisms in place to record the outcomes of peer review and ensure that the role is understood. The process of peer review includes:

- evaluation of nursing/midwifery care by someone with a comparable level of education, professional experience and/or employment status
- measuring practice against professional standards of practice
- providing non-judgmental feedback in a positive way that promotes professional development
- developing individuals and systems.

Peer review includes the additional following principles.

Feedback: [26]

- is timely, routine, and a continuous expectation
- is not anonymous
- incorporates the staff member's level of skills and knowledge.

TOP TIPS FOR PEER REVIEW

- ✓ Ensure nurses and midwives are clear about the purpose of peer review.
- ✓ Create transparent peer review processes.
- ✓ Support peers by providing open and respectful feedback.
- ✓ Foster positive communication between colleagues about their strengths and limitations.
- ✓ Learn from the knowledge and experience of colleagues.
- ✓ Instil the process of peer review as part of normal work unit routine.
- ✓ Identify clear outcomes during the peer review process to improve patient safety and professional practice.

COACHING

Coaching helps identify skills and capabilities in a person. It is collaborative and systematic and focuses on solutions and results. In the past, coaching has mainly been available to senior staff but it is now also seen as an essential component of the clinician role, particularly in the development of clinical leadership skills. The coach supports the learner to enhance their work performance, life experience, self-directed learning and personal growth.[27]

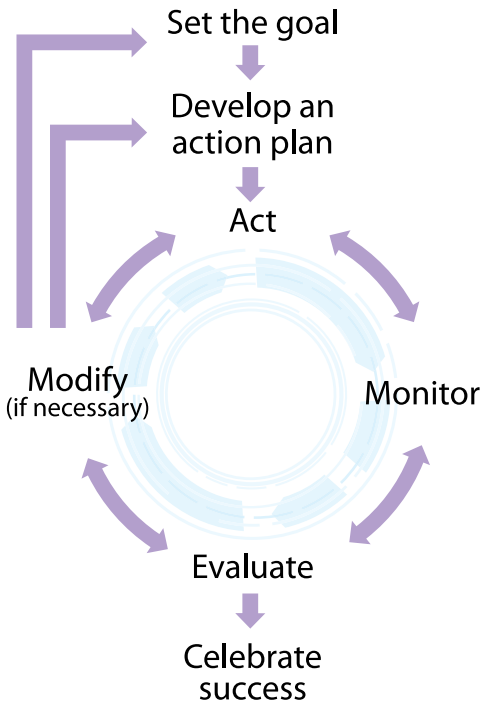
A coaching strategy is sometimes applied in the mentoring context. Other supportive relationships which may include coaching techniques are reflective clinical supervision and preceptorship. In this guide coaching is distinct from performance coaching which may be undertaken by a manager following a staff performance development review.

For more information of alternate coaching methods refer to the HETI Online Learning Centre (Moodle).[29]

what

WHAT is coaching?

Coaching is a process aimed at developing specific knowledge and skills, over a short time frame. Coaching usually involves a collaborative teaching, training or development process. One such model is below:[28]



Coaching in the context of a supportive and confidential relationship assists individuals to identify "self-concordant and personally valued goals" whilst "purposefully working towards achieving them".[28] This allows an individual to enhance their capabilities, and further develop existing skills.

Coaching is therefore a collaborative and systematic way of achieving identified goals.[28]

WHY is coaching important?

why

Coaching for specific skill and knowledge development is a useful strategy to support nurses and midwives and improve health care. Coaching provides focused support in the attainment of goals, and has been shown to build resilience and enhance self-regulation as the person receiving coaching (coachee) learns to overcome barriers. In addition, coaching may help increase staff well-being in challenging and changing work environments. [26]

Coaching can facilitate improved health processes and practices by:

- developing potential future leaders
- increasing competency levels
- supporting nurses and midwives when they undertake a new role
- improving the achievement of individual or ward/unit goals
- supporting nurses and midwives to function more efficiently
- providing effective support in challenging work environments
- reducing professional isolation.

WHEN is coaching provided?

when

Coaching may be offered as a strategy by the Nursing Unit Manager or Midwifery Unit Manager to meet future goals identified during the performance development review of a nurse or midwife. The nurse or midwife may have already identified coaching as a strategy from their personal reflection, or their manager may suggest this as an option.

Coaching is provided following discussion between the coach and the coachee, with support of the manager. A coaching agreement should be discussed and include the time frame for the coaching relationship, the frequency of coaching sessions and clear boundaries of the agreement.

how

HOW is coaching provided?

Coaching is commonly provided on an individual basis by a trained coach, although the principles of coaching may be learned and used by other staff. The coaching process includes the following broad components adapted from the International Coach Federation coaching core competencies. [30]

- Establishment of a coaching agreement.
- Planning and goal setting through effective communication.
- Facilitated learning.
- Design and implementation of actions.
- Review and evaluation.

The coach's role is to establish boundaries and use coaching models and techniques to assist the coachee achieve their identified goal. An effective coach will be trained, approachable, and available. The coach should have excellent communication skills, and have a positive outlook as they assist the coachee to progress through stages of the coaching process.

Seminal work regarding coaching outlines the GROW model principles of coaching whereby self-directed learning is implemented using stages of the process.[31] The acronym, GROW is often used as a reminder of the key components of coaching (Goal, Reality, Options, Way Forward), yet it is known that "there are many other goals that can be included in the coaching scenario"[28] including, but not limited "to learning goals, performance goals, distal goals and self-concordant goals".[28] The table opposite indicates these stages of the coaching process, and provides examples of questions a coach might use.[32]

	Stages	Examples of questions
GOAL	Identify and explore specific goals	What would you like to focus on? What control do you have in achieving this goal? How will you know you have achieved this goal?
REALITY	Explore the current situation and any assumptions	What have you tried so far? How is that working? What assumptions might you be making? How do you think others see the situation?
OPTIONS	Explore options and consider their positive and negative implications	How could you think about that situation differently? What options will help you achieve your goal? How comfortable are you with each option?
WAY FORWARD	Develop SMART goals (See Appendix 1) Agree on ongoing support and review dates	What do you need to do to move forward? What are your next steps? On a scale of 1 – 10, how committed are you to this goal? What support do you need from me/ others to achieve this goal?

The coachee role

The coachee has responsibility for being open to the coaching process, and for collaborating with the coach within the boundaries of the coaching agreement. Active participation in coaching is needed for the coachee to explore options and work towards achieving their goal within the agreed time frame. It is important that the coachee comes prepared for each coaching session.

The coachee also has a role in providing feedback to the coach in relation to the usefulness of the coaching sessions and anything that may impact on their participation in the coaching process.

TOP TIPS FOR COACHING

- ✓ Create a safe and supportive environment where confidentiality is maintained.
- ✓ Establish a professional relationship built on mutual respect and trust. Use active listening more than talking.
- ✓ Protect the time allocated for coaching from distractions and/or interruptions.
- ✓ Establish the focus of the coaching relationship, including an agreement for working together, in a way that encourages adult learning.
- ✓ Collaboratively identify, agree upon and work towards the coaching goals rather than making assumptions about what the coachee wants to learn.
- ✓ Empathise, show patience and allow the coachee to express feelings rather than dominating or controlling the coaching experience.
- ✓ Ask appropriate open, and enabling questions that facilitate clarification, reflection and growth.
- ✓ Critically explore the coachee's situation and develop options with them to move forward.
- ✓ Encourage the coachee to identify their strengths.
- ✓ Stay calm and patient and remember what you experienced when you were learning and developing.

Coaching - Scenario 1
(Communication/change of patient status)

scenario

Priya is a Registered Midwife who has recently moved to Australia from India. She is caring for a young mother in the birthing suite, following a long labour. It has been half an hour since birth, when Priya notices a change in the woman's condition. She has become tachycardic (110bpm), and hypotensive (90/50mmHg). Her respiratory rate has increased to 26 breaths per minute. Priya examines her pad, and finds significant PV blood loss. She feels for the fundus of the uterus and it is above the umbilicus and not contracted. She commences fundal massage and calls for assistance.

Priya notifies Katrina, the midwife in-charge, of the change in the woman's status. Katrina asks her to phone the obstetrics registrar to inform him of the change, while she examines the woman.

Priya is hesitant and stumbles through the handover. "Hello doctor? Hi, um, my patient in bed 3 is not well. She is unstable. What do you want me to do? She feels ok, um, but she's a bit drowsy. There's been some bleeding too. And her blood pressure is a bit low…"

Katrina overhears Priya's conversation with the doctor. She leaves the bedside and approaches the desk. Shaking her head, she takes the phone out of Priya's hands and takes over the conversation. When she has finished speaking, she hangs up the phone and turns to Priya. "You can't talk to the doctors in that way Priya! You sound like you haven't got a clue what you're talking about. You need to learn to prioritise the information. Did you take note of the way I said it? That's how it should be done. Haven't you ever heard of ISBAR? (See Appendix 6). Look, here is some information on it (handing Priya a leaflet). Read over it, but from now on just come and see me when there is a change in your patient's condition and I'll call the doctor for you. Ok?"

Priya is embarrassed. She returns to the bedside, but appears nervous and unsure of herself, continuously calling Katrina over to double check all of her observations. The doctor comes to assess the woman, and she is treated for a moderate postpartum haemorrhage. When stable, she is transferred to the postnatal ward with a comprehensive handover.

Louise is one of the senior midwives working on the ward. She witnesses this exchange, and sees that Priya is visibly upset and embarrassed at being told publicly that she has performed badly.

Louise approaches Priya at the end of the shift. She empathises with Priya, acknowledging that it can be difficult to communicate clearly and concisely when under pressure. She informs Priya that she is a trained coach, and offers to coach Priya on how she might handle the situation differently in the future. Priya seems relieved and is very receptive to the offer of coaching. Louise arranges to meet with Priya an hour before their shift the next day to discuss their coaching agreement.

The following day, Louise and Priya meet in a quiet area of the courtyard outside the hospital. Louise begins by praising Priya for detecting the change in the woman's condition. She then spends some time with Priya, explaining goal setting and outlining the structure of the session. She explains that coaching can be empowering, by enabling people to build on their strengths and explore different ways of responding to challenges.

Louise asks Priya what she would like to learn, followed by a series of questions to identify motivating factors and external distractions that may influence the coaching process.

Both she and Priya identify communication as an area of Priya's practice that requires some improvement. Priya agrees to be coached by Louise over the next two weeks (short term), focusing on the area of communication, specifically communicating a change in a patient's condition (narrow focus). The aim of the coaching is to achieve an immediate improvement in performance. It is agreed that the Midwifery Unit Manager will be informed of Priya's progress during the coaching process, but that confidentiality will be maintained. Issues that are discussed in her sessions will not be shared with other members of the team, unless it is felt that her actions compromise.

Louise asks about Priya's past experiences communicating with medical staff. "In your previous workplace, how would you go about communicating a change in a patient's status? How do you feel about handing over information about a patient's condition to medical staff?"

Priya states that she is unfamiliar with interdisciplinary handovers and lacks confidence in speaking with doctors. As a junior midwife in her previous workplace, she would rarely speak directly with doctors about concerns regarding a patient. The usual practice was to inform the midwife in-charge of any problem, so that he/she could relay the information to the medical staff. Priya says that she has found some of the junior doctors at the hospital abrupt and impatient in their manner, and that she has often felt intimidated by them.

Priya and Louise discuss some external pressures that may be impacting on Priya's work life. They discuss the challenges of moving to a new country and adjusting to a new workplace, with new routines and expectations. Louise recommends a meeting with the Midwifery Unit Manager, to increase the support provided to Priya during this period of adjustment. She suggests discussing the possibility of additional supernumerary days, formal coaching programmes and ongoing clinical supervision.

Louise also asks Priya to consider how she likes to learn. Priya states that she prefers one-on-one teaching and watching demonstrations, and also finds it useful to have reading material she can look over in her own time.

Louise works with Priya in developing a short term goal for the purposes of their coaching. It is established that Priya wishes to demonstrate the ability to prioritise information when communicating a change in a patient's status using the ISBAR tool.

Some strategies to achieve Priya's goal are discussed, taking into consideration her learning style and preferences. Priya identifies a Clinical Midwifery Educator who can

assist her to practice examples of clinical scenarios, giving her the opportunity to practice her communication skills away from the bedside and receive immediate constructive feedback on her performance. Priya also plans to ask the educator for written educational resources to understand DETECT (Detecting Deterioration, Evaluation, Treatment, Escalation and Communicating in Teams). Priya sets another action to read over the material and complete the online learning package on effective use of ISBAR in clinical handover. Lastly she plans to ask her Midwifery Unit Manager for support to attend the DETECT workshop run by the hospital.

Louise arranges to be available at work to assess and evaluate her progress on a daily basis. She plans to assess Priya's ability to prioritise information and communicate effectively by observing her communication at midwifery handovers, and by being available to observe and assist her in communicating with medical staff. They also arrange to meet at the end of the two week period for a formal evaluation of Priya's performance. During this evaluation, Louise will ask Priya to explain ISBAR, and assess her ability to use it effectively during practice clinical scenarios.

Louise provides ongoing feedback over the two week period, and holds a private feedback session at the completion of the coaching period. Louise praises Priya for her participation and enthusiasm, and encourages her to acknowledge the improvement in her performance during handovers. Priya recognises that the coaching process has assisted her to set and action goals. It is agreed that some additional coaching sessions would be helpful to further develop her confidence and competence regarding communication. An extended period of coaching is discussed, to be implemented in combination with other supportive strategies developed by the Midwife Unit Manager and educator.

SCENARIO QUESTIONS

1. What was the outcome of Katrina's interaction with Priya?
2. How did Louise determine how to best provide useful support through coaching for Priya?
3. What aspects of this clinical situation were of most concern to Priya?
4. What steps did Priya plan to take to increase her communication skills and confidence?
5. What support do you receive in the workplace if you are unsure or lack confidence in communication?
6. What is your experience of coaching?

MENTORING

Mentoring can be provided by someone in the same or different area of practice. In a mentoring relationship, the supervisor undertakes to share knowledge and expertise for an extended period, in order to further the nurse or midwife's professional development.

what

WHAT is mentoring?

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

why

WHY is mentoring important?

Mentoring is a way to nurture and support nurses and midwives to continue to grow professionally and develop their careers.

Mentoring helps to maintain and develop leadership skills and opportunities for nurses and midwives to work in senior roles.

when

WHEN is mentoring provided?

Mentoring is usually commenced at the instigation of the mentee. The frequency of the meetings is dependent on the availability of the mentor and the mentee. Mentoring relationships may last for a number of years.

how

HOW is mentoring provided?

Mentoring may happen outside of the workplace. It can be an informal relationship that has evolved naturally between two people or a more formal arrangement where the mentoring relationship is arranged by another party.

The mentor role

Successful mentoring depends on how motivated the experienced individual is to participate and effectively fulfill their role as a mentor. Important aspects of mentoring include:

- guiding and passing on knowledge to the mentee
- coaching the mentee to improve their knowledge
- sponsoring the mentee by exposing them to work that will build skills to benefit their future career.

A mentor helps develop the mentee's knowledge about other aspects of the organisation by giving them projects where they will be exposed to and interact with key stakeholders in the organisation. The mentor sometimes acts as a teacher by allocating challenging work assignments then providing technical education and feedback. The mentoring relationship can continue over a significant period of time.

The mentee role

As this commitment is self-appointed, it is important to respect the commitment that the mentor is making and this is achieved by a nurse or midwife when you:

- know what you need and want from the relationship
- have clearly-defined objectives
- treat the mentor relationship with care, by being respectful of your mentor's time
- identify your issues that may interfere with reaching your objectives
- consider committing time outside of regular work in order to fit in with your mentor
- communicate your needs and how you think your mentor could assist you
- commit to actions and suggestions that you have discussed with your mentor.

A mentoring agreement

Like all partnerships, it is important to understand the expectations of both parties. A mentoring partnership agreement describes expectations and responsibilities and is particularly useful in formal mentoring programmes. When creating an agreement, it is important to address the practical aspects of regular meetings, goals and objectives, feedback and reflection, and needs commitment from both parties. These include the mentee's expectations and learning needs, the mentor's expectations, meeting arrangements, timing, learning strategies to achieve results, and the mentee's ability and commitment.

To get the most out of mentorship meetings they should be planned and structured. The next step is creating a plan to map the proposed vision, establish tools and resources for the mentee to develop capability, and learning strategies to help consolidate knowledge and skills.

A mentoring plan

To be successful it is essential to determine a reasonable and achievable time frame for each task or experience. The timeframe needs to include time for the mentor to monitor and evaluate progress.

The mentorship arrangement must have a learning and development plan to give the mentee focus and structure to achieve their identified goals.

Essential components are:

- the mentee's vision, identified strengths and weaknesses
- specific goals and objectives to achieve the mentee vision that are measurable and achievable in the specified time frame
- specific learning opportunities to gain exposure to new ideas such as conferences, meetings, committee participation, books, journal articles and strategic networking opportunities
- possible learning opportunities that will provide exposure to new skills and knowledge
- a list of possible resources to help build and develop capacity. Consider resources both within and outside of the organisation
- agreed strategies to achieve goals and objectives
- specific set goals with target dates to review progress and learning. An essential mentoring arrangement clearly outlines goals and objectives.

Critical questions and timely constructive feedback are essential. It is often helpful to have a plan or agenda about what kind of issues will be reviewed during the meeting. Discussion about the mentor's own experiences and lessons learned offers valuable insight for the mentee, as well as providing a respectable and credible role model.

TOP TIPS FOR MENTORING

- ✓ Foster a learning environment.
- ✓ Monitor and evaluate progress.
- ✓ Build trust to sustain the mentorship relationship.
- ✓ Provide guidance and support with challenges.
- ✓ Promote reflection and insight into previous experiences.
- ✓ Listen and facilitate self-awareness and independence.

Mentoring – Scenario (New Nursing Unit Manager)

scenario

Pippa has been employed in the coronary care unit as a Clinical Nurse Specialist for the last five years. During this time, she has mostly been in charge of shifts after hours and occasionally acted as Nursing Unit Manager. Recently, the Nursing Unit Manager position became vacant and was advertised when the previous manager moved to another position. Pippa has applied and been told that she is the preferred applicant. The Program Manager meets with Pippa and suggests that a mentorship programme would help her to further develop the leadership abilities she will need for the position. The Manager suggests a number of senior nurses within the hospital who would be suitable and willing to provide mentorship support.

Jan has been a senior nurse manager in the organisation for the last ten years. Pippa approaches Jan and asks Jan to be her mentor. Jan agrees to provide some informal mentoring and they arrange to meet at a coffee shop to discuss the mentoring relationship.

Jan greets Pippa warmly, smiling and shaking her hand. "I was very pleased when you approached me and asked me to be your mentor. I can see you are motivated and have strong initiative. I am impressed with your commitment to achieving your best by seeking help and advice. I am more than happy to provide that where I can, and refer you on to the experts if we run into territory I am not familiar with". Pippa is encouraged by Jan's openness and her positive and motivational attitude.

They sit down and Jan asks if Pippa has ever experienced any formal or informal mentoring in the past. Pippa states that she has, but that she had felt she and her previous mentor did not seem to share the same values and views, and that they had not been able to develop a comfortable rapport. Jan acknowledges that mismatching of personalities and attitudes can be a barrier to successful mentoring, but that she hopes they will not experience this problem.

Jan begins by offering to tell Pippa about her current role and her career to date. She describes some of her career highlights, as well as challenges, identifies role models, and describes her areas of interest and expertise.

Jan suggests they start by establishing an agreement about the terms of their mentoring relationship. It is mutually agreed that the meetings will be confidential, and based on respect, honesty and a shared commitment to learning. Jan encourages Pippa to view their mentor/mentee relationship as a forum to share feelings as well as facts, but that boundaries also need to be established. They agree that healthy ventilation of feelings is acceptable, but that gossip or negative topics would be off limits. Personal issues impacting on work may be discussed, but extremely personal information should be withheld.

Jan encourages Pippa to be open and honest about her feelings and concerns, and hopes she can provide support and empathy. They agree to meet on a monthly basis, or according to need. It is decided that their place of meeting should ideally be outside of work, unless they require the use of hospital facilities for coaching purposes. It is agreed that they both be accessible between sessions by mobile phone and email. Jan also states that she is happy for Pippa to approach her in the workplace if she wishes.

In order to develop an understanding of Pippa's needs, Jan asks Pippa what she would like to learn from the mentoring experience. She asks Pippa to describe her current role and leadership experience, her skills and areas of interests. She asks about Pippa's expectations and aspirations regarding her career and the mentoring process. "What would you like to gain from this relationship? Do you have any concerns about your new role? What skills would you like to have? What challenges do you see in becoming a successful leader?"

Jan uses active listening to help set mutual goals to achieve Pippa's needs and guide their relationship. Pippa recognises some deficits in her current leadership knowledge and skills. Her learning goals surround aspects of administration, such as budgeting and rostering, as well as human factors, such as motivating staff and dealing with conflict. Her goals include being able complete the required managerial administrative tasks under the supervision (initially) of the Program Manager. She also wishes to learn and apply techniques to provide feedback, motivate staff and manage conflict within the ward. Her professional goal is to achieve recognition as a competent and efficient manager, allowing her to move her career into the area of health education and policy development (her area of interest). Her personal goal is to maintain adequate work life balance, allowing her to continue to spend time with her boyfriend and maintain her current sporting interests.

Jan asks Pippa how she might go about achieving these goals and together they build an action plan, outlining this on a timeline. As an expert in her field, Jan is able to act as a resource person for Pippa, providing expert information and advice, and coaching her on completing administrative tasks. Jan is also able to guide her in managing the human resource aspect of her role. In addition to her advice on these matters, Jan recommends a number of courses and conferences run by outside organisations that may expose Pippa to new concepts and research regarding human factors. For example, performance management or conflict management. Jan offers to assist Pippa in refining her notions of future career direction by exposing her to other aspects of the organisation, such as committees and journal clubs, and providing networking opportunities with contacts outside her current organisation. For example, attendance at conferences relevant to her areas of interest.

Jan considers some of the challenges she experienced in maintaining healthy personal relationships and work/life balance when at Pippa's age and stage of career. She acknowledges that this is a difficult but important consideration, and one that is often overlooked. She reflects on her own experience and shares this with Pippa, offering advice on strategies that she found helpful or unhelpful in the past.

Pippa and Jan end their meeting by reflecting on the mutually agreed terms of the mentorship. They arrange to meet at Jan's office in one month's time, to evaluate and review the goals. Jan encourages Pippa to contact her in between meetings if new issues arise that she wishes to discuss. Pippa thanks Jan for her enthusiasm and commitment and says that her support and encouragement has given her confidence to tackle her new role.

Scenario Questions

1. Why would a mentorship programme be helpful for Pippa?
2. How did Jan establish the mentoring relationship with Pippa?
3. What skills does Jan use as a mentor to empower and enable Pippa?
4. What possible strategies do Pippa and Jan explore to assist in Pippa's skill development?
5. Where do you receive your support in career and skills development?
6. What is your experience of mentoring?

SECTION 4

Clinical Supervision (Reflective)

CLINICAL SUPERVISION (REFLECTIVE)

CLINICAL SUPERVISION (REFLECTIVE)

Reflective clinical supervision is a new practice in nursing and midwifery, although it has had a long history in mental health nursing. Internationally, clinical supervision is increasingly recommended as an important component of continuing professional development. In addition, recent policy documents, guidelines and framework documents for nurses and midwives in NSW note that health services should ensure staff receive clinical supervision on a regular basis.[33,34] Position descriptions in some NSW Local Health Districts now contain participation in clinical supervision as a means of supporting staff in the provision of safe and effective health care. Reflective Clinical Supervision in this guide will also be referred to as clinical supervision.

what

WHAT is clinical supervision?

The term clinical supervision is used in a variety of ways to describe dedicated time to reflect on clinical practice and situations in context of the work environment. Clinical supervision may also be called professional supervision by allied health workers,[35] adding to the range of understandings and uncertainties about its meaning.[36]

No single definition fits all models and professions, however as a minimum, the definition "regular, protected time for facilitated, in-depth reflection on clinical practice"[37] is commonly used. Due to the difficulty of defining clinical supervision, the following definitions are also provided:

"A process within which the clinician brings his or her practice under scrutiny in order to more fully appreciate the meaning of their experience, to develop their abilities, to maintain standards of practice and to provide a more therapeutic service to the client"[38]

"The provision of empathetic support to improve therapeutic skills, the transmission of knowledge, and the facilitation of reflective practice. This process seeks to create an environment in which the participants have an opportunity to evaluate, reflect and develop their own clinical practice and provide support for one another."[39]

Note: Clinical supervision is not:

- the supervision or oversight of clinical work by another staff member in a line management role
- individual performance review
- a form of disciplinary procedure
- preceptorship or mentoring
- critical incident debriefing
- psychotherapy or counseling.

In order for time and space to be available for reflection, personal and organisational commitment is needed to protect regular clinical supervision from other competing organisational commitments.

Examples of what to bring to clinical supervision:

The supervisee should decide what is important to them and be encouraged to focus on a work practice issue. Examples of clinical supervision topics include, issues arising from patient care and interactions with patients and/or other staff members. In addition, clinical supervision provides the opportunity to reflect on traumatic experiences in the delivery of health care, and ethical and moral issues. Other examples of areas of reflection include professional boundary issues, maintenance of professional standards and the challenge of working in a large organisational system. (See Appendix 4 –Supervision Session outline example)

WHY is clinical supervision important?

why

The overall purpose of clinical supervision is to provide the best available standard of care. In a relationship based on trust and openness, clinical supervision provides the opportunity for supervisees to review and reflect on their work to be able to improve in future.[40]

Benefits of regular clinical supervision[36]

- Increased feelings of support, job satisfaction and morale.
- Promotion of work-based learning and the development of new skills.
- Increased professional discipline, growth and identity.
- Improved recruitment and retention of staff.
- Beneficial risk management strategy for organisations.
- Promotion of quality assurance and competent best practice.
- Reductions in professional isolation, levels of stress, emotional exhaustion and burnout.

when

WHEN is clinical supervision provided?

The support provided through clinical supervision can be provided at any stage of professional development, in a variety of contexts:

"The process of clinical supervision should continue throughout the person's career, whether they remain in clinical practice or move into management, research or education".[37]

It is recommended that clinical supervision sessions are held at least monthly during work time. More frequent sessions may be required during periods of transformation and/or difficult or stressful periods in the workplace.

how

HOW is clinical supervision provided?

Clinical supervision is provided on an individual or group basis, usually by a more experienced and trained supervisor. Increased satisfaction with the quality of clinical supervision has been noted when staff can choose their supervisor, and the sessions are held away from the workplace.[41]

The supervisor role

A supervisor of clinical supervision should have received appropriate and validated training to confidently guide the reflection process, and also be receiving regular clinical supervision themselves.[37] Peer supervision is another method of conducting clinical supervision, where peers alternate in the supervisor role.

There is no single approach to providing clinical supervision, and the supervisor may utilise a range of models and techniques. The supervisor does not need to have experience in the same clinical or professional area as the supervisee. The focus is on enabling the supervisee to learn by reflection instead of concentrating on the detail and technical aspects that may be more appropriately addressed in case review, case conference or debriefing.

The supervisor is responsible for:

- creating a safe environment for reflection
- monitoring the supervisory relationship
- session time management
- monitoring ethical issues
- reviewing the sessions periodically.

The supervisee role

The supervisee is responsible for:

- committing to regular supervision
- bringing an issue/topic for reflection to supervision
- being an active participant in the supervision session
- being willing to learn and change in the process of receiving support and being challenged in their thinking
- taking active steps in response to their reflection and learning.

Reflection leads to understanding at different levels and learning how to do things differently in an enhanced way. The table below provides examples of reflective questions, ranging from the identification of what happened, and progressing to reflecting on how to implement an action arising from the process.[42]

Experiential Learning	Process	Focus	Method
Action	Objective	What happened? Is happening?	Observe facts, events, notice, give attention
Reflection	Reflective	What am I feeling? What is my reaction?	Monitor and articulate reactions
Reflection Learning	Interpretative Integrative	What does it mean? What have I learned?	Utilise critical thinking Assimilate into new learning
Application	Decisive	What do I do?	Implement

Reflection on feelings and reactions may prompt the supervisee to consider their personal values and assumptions about patients and other staff. Clinical supervision can assist nurses and midwives to provide respectful care by increasing their level of cultural competence[45], sensitivity and acceptance of others. The term cultural supervision incorporates understanding the culture of different ethnic groups and sub-groups[35], and is an important area of reflection for nurses and midwives.

The clinical supervision agreement

A written or verbal supervision agreement is useful to define the supervisory relationship and state broad roles and responsibilities for the supervisor and supervisee. Both the supervisor and the supervisee/s are responsible for negotiating an agreement (also known as a contract), acceptable to both parties. If the agreement is with a group, the supervisor may have an agreement with each supervisee (See Appendix 2 Reflective supervision agreement example).

Both parties may agree to some kind of record (See Appendix 3 Supervision feedback form example and Appendix 5 Supervision log example) of the themes and learning they experience. Records of attendance may be requested by managers and can be utilised as evidence required for annual registration. The supervisee is responsible for recording attendance and liaising with their manager regarding sessions.

Supervision sessions are confidential unless there are legal, ethical or safety issues requiring management outside of the supervision session. If so, the supervisee will be supported to take appropriate steps and be provided with support to do this by the supervisor as required.

Individual clinical supervision

Individual clinical supervision occurs when a supervisor meets with one supervisee. This has been the approach for allied health professionals[35] and mental health nurses however it is becoming more common in areas of nursing and midwifery practice. Individual clinical supervision sessions are usually held for an hour.

Advantages of individual supervision[37]

- The supervisory relationship can develop more quickly and deeply.
- More continuity, same clinical supervisor each time.
- More time to reflect in depth.
- Easier to arrange times.
- Gives more of a sense of being listened to as an individual.

Disadvantages of individual supervision

- May be too intense for supervisees who are unfamiliar with the support provided during clinical supervision practice.
- The supervisor and the supervisee may be mismatched in some way.
- The supervisee only gets one other perspective of an issue.

Group clinical supervision

Group clinical supervision can be provided for staff from the same clinical specialty or team. However, a group comprised of supervisees from a variety of nursing backgrounds, or a multidisciplinary group, has the potential to provide a range of insights. Ideally, participants should be able to choose their supervisor and their group from a database of accredited supervisors in the organisation. The number of supervisees at any session should not exceed four (4) to six (6) supervisees who meet for at least one and a half hours.

Advantages of group supervision include:

- the chance to hear about the work of others and learn from it
- a wider range of feedback options
- that it can normalise events in your own work situation to realise other staff experience similar challenges
- greater opportunity for emotional support due to additional supervisees
- the potential richness when a number of supervisees reflect together
- that managers may consider clinical supervision in a group provides value in terms of time, money and use of available supervisors.

Disadvantages of group supervision, adapted from Bond and Holland,[37] include:

- individuals can get differing amounts of air time (if not the supervisee)
- high level of skill needed. Participants need supervisee skills and supervisor needs supervisor and group facilitation skills
- non-committed individuals may hide and say little
- difficulty in arranging a convenient time for sessions
- challenges in continuity if different people attend each time
- group dynamics can be detrimental, if the group isn't managed appropriately by the supervisor.

TOP TIPS FOR CLINICAL SUPERVISION

- ✓ A structured process should be followed to increase the effectiveness of the session.
- ✓ All supervisors should receive clinical supervision themselves to monitor and develop the quality of supervision provided.
- ✓ Confidentiality and boundaries should be agreed between the supervisor and supervisee/s at the beginning of each session to create a safe, supportive environment.
- ✓ The clinical supervision agreement should be reviewed at least three monthly by both the supervisor and supervisee.
- ✓ Gain managerial support and sponsorship to implement and sustain regular clinical supervision sessions.
- ✓ Good supervision practice involves the supervisee identifying actions or ways to move forward. A supervisor should not impose their solutions on the supervisee.
- ✓ Utilise a venue away from the main workplace area to minimise interruptions.
- ✓ At the end of each session, confirm the date, time and venue for the next session. Where possible, plan appointments for the three or more months in advance.

"Supervision is a life-long process. It can be used anywhere, where people, their creativity, initiative, productivity and their quality are respected and valued." [43]

"To enter a session feeling unsure, tense, stressed, perhaps anxious, upset or angry and to leave relaxed, clear in focus, confident and developing in competence is what clinical supervision is all about." [44]

Reflective Clinical Supervision - Scenario 1 (Individual reflective clinical supervision)

Kim is a new graduate registered nurse undertaking a new graduate programme at a tertiary hospital. She is halfway through her programme when she is involved in a cardiac arrest on the ward. Fortunately, the patient is successfully resuscitated. However, an incident occurs during the arrest, where the attending registrar shouts at Kim. This causes her great distress and embarrassment, and damages her confidence.

The following day, Kim's Nursing Unit Manager approaches her on the floor during the busy morning shift (surrounded by colleagues and patients). She says "I hear you were really upset and might need some counselling after what happened during the arrest the other day. I am free now, come into my office." Kim follows her Nursing Unit Manager into the office, feeling embarrassed that the issue was raised in front of her colleagues and other patients. Kim also feels uneasy about burdening her colleagues with her workload while she is in the office. The Nursing Unit Manager sits behind her desk. She says she heard what happened, that Kim should take no notice of what was said by the doctor, and that she just needs to stand up for herself next time and be more assertive. Kim leaves the office still feeling uneasy about the incident and unsure about how to move forward or deal with her feelings.

Kim has previously commenced regular reflective clinical supervision with Mark, a Clinical Nurse Consultant affiliated with the new graduate rotation programme. Kim feels comfortable speaking with Mark, as she is aware reflective clinical supervision should be provided by a person trained as a clinical supervisor, and outside the line-management of the supervisee. The sessions are held monthly for an hour in Mark's office, at a dedicated time when Mark can provide his full attention.

Mark welcomes Kim to their planned clinical supervision session, two days after the cardiac arrest incident. The roles and expectations of supervisor and supervisee were established between Mark and Kim at their first session. After an initial 'warm up' conversation, Mark reminds Kim that the session is confidential, except if there is a danger of harm to herself or others, or there is a boundary issue requiring action. In this event, the appropriate steps would be taken to address the issue, whilst providing support to Kim. Mark turns his phone off, reminds Kim that she has his complete attention for one hour, and then asks "What would you like to bring to clinical supervision today?"

Kim explains that during a shift she entered a patient's room to find the patient unconscious and not breathing. She called for help and pressed the emergency buzzer. A number of doctors and nurses came running in and CPR was commenced. Kim becomes tearful and upset whilst describing the event. She describes feeling completely overwhelmed. Mark empathises with Kim, acknowledging that an arrest situation can be very intense and overwhelming. Mark then confirms that the purpose of the session is to explore and better understand Kim's experience of the events related to the emergency. Kim agrees.

Mark asks Kim to continue to describe exactly what happened. Kim explains that she stood back while more experienced staff took over, but remained in the room and helped by handing out equipment from the arrest trolley. A decision was made to intubate the patient. The doctor performing the intubation turned to Kim and asked her to prepare the equipment for intubation. Kim states that she was unsure of what equipment was required and began fumbling through the drawers of the trolley and handing various pieces of equipment to the doctor. At this point, the doctor became irritated and shouted at her, saying it was the wrong equipment and that she should leave if she did not know what she was doing. Another nurse stepped in to help and Kim left the room, close to tears.

Mark asks Kim to focus on how this made her feel at the time. Kim reflects on her response and says she felt hopeless and useless and incompetent as a nurse. She also felt embarrassed and humiliated in front of her colleagues. She says that at the time she began to question whether the whole incident was her fault and whether she had caused it by being so incompetent. She says it has continued to upset her and is causing her to doubt herself and her clinical judgment.

Mark asks Kim to reflect on the response of the doctor and consider why he may have reacted the way he did. Kim states that he probably felt very stressed and under a lot of pressure because time was critical and he was the one responsible for the intubation. Mark goes on to question the response of the doctor, asking Kim to consider whether he had communicated his wishes clearly and appropriately.

Mark also queries what the noise level was like in the room, and how other people were responding. Kim says it was frantic and that many other people were also shouting orders. Mark asks Kim to reflect on the scenario from the perspective of her colleagues in the room. "Did other people hear what the doctor said to you? How did they respond?" Kim replies that it was unlikely that others in the room heard or paid much attention to what was said, as everyone was very busy and focused on their own tasks and their own stress levels.

Some further questions are then asked by Mark to better understand the impact of the situation on Kim. He asks Kim to consider whether she felt she acted within her scope of practice. "On reflection, do you feel you were negligent in any aspect of your care?" Mark also asks Kim to consider whether she felt she had the trust and respect of her colleagues, and if she believed the interaction would have changed their view of her. He then asks if she has ever witnessed a similar outburst in the past, and if so, how she and others responded to that incident.

Kim responds, stating that she does not feel she was negligent or responsible in any way for the arrest. She says she feels she is generally respected by her colleagues, and that the words of one person in the middle of a critical incident would not alter their view of her. She acknowledges that she acted within her scope of practice, and that it is the responsibility of all members of the team to support less experienced staff in

an arrest situation. Kim adds that whilst she hasn't witnessed many emergency events, she has witnessed several incidents in the hospital where someone was abused or criticised publicly, and feels such behaviour shouldn't be tolerated.

Towards the end of the session, Mark reviews the session purpose and summarises the discussion, confirming that Kim was feeling distressed and doubted her competence in a crisis situation. Through examining the responses and perspectives of others involved in the incident, and reflecting on Kim's past experiences in similar scenarios, Mark is able to guide Kim's reflective thinking. He assists Kim to understand the scenario in a way that allows her to consider how she might be able to respond more appropriately if a similar situation were to occur again.

Mark then asks Kim to consider what steps/actions she will take to feel more composed and in control in an emergency situation. The first thing Kim identifies is that she requires further education to familiarise herself with the equipment on the resuscitation trolley. She plans to discuss this with the Nursing Unit Manager and Clinical Nurse Educator, and organise an education session. In addition, Mark asks Kim if she would like to talk to the doctor about what happened during the cardiac arrest. Mark and Kim briefly discuss how this might occur and Kim suggests this could be the topic of a future reflective clinical supervision session. Kim adds that she may also wish to have a conversation with the Nursing Unit Manager regarding their interaction. Mark informs Kim that the Employee Assistance Programme (EAP) is also available to her, should she require further support. Kim says she is fine and that raising this issue today was most helpful to her.

During the session, Mark has made brief notes, including the next steps/actions Kim plans to take. Mark thanks Kim for coming to the reflective clinical supervision session, and hands her the notes representative of the session's work. The session concludes as Mark and Kim confirm the date, time and venue for the next session.

Scenario Questions

1. What helped Kim discuss her distressing experience with Mark?
2. How did Mark determine how to best provide useful support to Kim during the reflective clinical supervision session?
3. What factors in the cardiac arrest incident were of most concern to Kim?
4. What steps did Kim plan to take to increase her clinical skills and confidence?
5. Where do you receive support if an incident or interaction in the workplace causes you distress?
6. What is your experience of reflective clinical supervision?

SECTION 5

Challenges

Common challenges for supervisors

The goal of supervision is to bring out the best in people. There are often challenging moments on the way to this goal. The challenges are unique to the individual and require solutions tailored to the circumstances. Many problems can be avoided by carefully orienting the supervisee to their role and to the organisation, setting clear expectations and establishing or clarifying a supervision contract. This will go a long way towards preventing any misunderstandings and alert the supervisor to issues that may need management.

It is recognised that, in the past, most clinicians received little or no formal training in managing staff issues and often acquired these skills through experience and/or modelling other senior staff behaviour. It is important that supervisors and managers invest in their own professional development and supervision to improve confidence in managing complex issues.

Challenges and solutions

The clinician with communication problems: Does the nurse/midwife recognise that communication is a problem? If yes, remediation can be relatively straightforward (for example, writing courses, conversational practice, providing scripts or templates to model effective communication practices, providing a mentor or buddy, use of audio-visual equipment). If no, then the issue is more complex, because the solution has to begin with the nurse/midwife gaining insight into the problem. For example, members of the clinical team may report that the clinician is impolite and uncommunicative while the clinician considers that he/she is efficient and focused. Readjusting the clinician's perceptions involves developing his or her empathetic ability and, if identified as a problem, should become the focus of supervision.

The clinician who is uninterested in the area of clinical work: It is best to identify this early and plan accordingly. In some instances, the clinician's lack of interest will be based on a misconception of the content of the work or on a failure to appreciate its relevance to their area of interest. In many cases, the supervisor can highlight aspects of the work that will be of interest to the clinician. In others, an appeal to the clinician's sense of responsibility to the team may motivate them.

The reluctant supervisee: Where the nurse/midwife has no interest or cannot see the benefit of supervision. The supervisee needs to be encouraged to see the importance of supervision as part of professional development and delivery of safe patient care. Ensure the supervisory relationship and process appropriately meets the needs of the supervisee.

The overconfident clinician: Overconfidence is potentially dangerous and it is important to provide a reality check at an early stage. This may occur by asking the clinician to provide advice on a hypothetical case and then through guided questioning, give a constructive critique of their management plan. Consider highlighting the potential consequences of overconfident practice in relation to a real patient. This should not be undertaken in a way that will belittle or embarrass the clinician.

The perfectionist clinician: Some clinicians are so determined to do everything perfectly that they cannot meet realistic deadlines and are in danger of burning themselves out. It is important with these staff to develop an appropriate priority list and work on realistic time management skills.


NSW HEALTH

SECTION 6
Conclusion

Conclusion

This guide builds on existing knowledge and for the first time provides a resource that articulates components of supervision within one document. It is not designed to provide an in-depth analysis of each area of supervision, its purpose is to provide an overview and generate further discussion within the clinical environment. A toolkit will also be available to support knowledge acquisition.

The Superguide: A Supervision Continuum for Nurses and Midwives provides nurses and midwives in NSW with a quick reference guide to different types of supervision.

The guide endeavours to provide guidance and raise awareness of different types of supervision supporting nursing and midwifery practice. Supervision is viewed as a positive approach to providing safe person-centred care and maintaining the optimal health and well-being of patients and staff.

Nurses and midwives at all levels of professional experience benefit from supervision as they provide or receive oversight of professional practice. Professional development is a continuing process, and it is the responsibility of all health care professionals to not only maintain their own development, but also to take an active part in supporting less experienced colleagues on a day-to-day basis. The guide, and linked resources, provides assistance for nurses and midwives to receive support, and support each other.

Key features of The Superguide: A Supervision Continuum for Nurses and Midwives:

- The Supervision Framework
  - Includes a visual representation of:
    - Point of Care Supervision
    - Facilitated Professional Development
    - Clinical Supervision (Reflective)
- The Types of Supervision for Nurses and Midwives table
  - An easy reference guide outlining different types of supervision
- Scenarios, videos and access to toolkit
  - To assist in understanding different types of supervision and how they are implemented

Working together, reflecting on interactions with patients and carers, and supporting staff professional development needs, provides the basis of improved health care and patient satisfaction with nursing and midwifery services.

The development of The Superguide: A Supervision Continuum for Nurses and Midwives opens the way for increased dialogue, and further development of resources to support NSW nurses and midwives in their professional practice.

APPENDICES

APPENDIX 1

Smart goal template example

SMART goals need to be Specific, Measurable, Achievable, Realistic and Timely *(Doran 1981)*.

SMART goal:
Specific steps:

SMART goal:
Specific steps:

SMART goal:
Specific steps:

APPENDIX 2

Reflective Supervision Agreement example

Date of agreement:

Clinician:

Clinical supervisor:

Team leader:

Review date:

1. Clinical supervision will address the following areas:

2. Clinical supervision will take the following form and frequency

(For example. 1:1 meeting, team meeting, peer shadowing):

3. Confidentiality

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

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

Other areas to consider:

4. Record of clinical supervision

Who will record it?

Where will the records be kept?

Who has access to this information?

What will happen to the clinical supervision notes when:

The clinician leaves their position?

Notes will be maintained/archived in line with record management policies.

Additional information:

5. Clinical supervision meetings (if applicable)

The clinician will prepare for each meeting by:

The clinical supervisor will prepare for each meeting by:

Should a meeting need to be rescheduled we agree to:

5 Other considerations

The details of this document can be modified at any time when agreed by both parties.

A copy of this agreement will be given to the team leader/line manager for their records.

Signed: Date:

Name:

Signed: Date:

Name:

Source: Port Augusta Hospital and Regional Health Service, cited in Allied Health Clinical Support Framework, Country Health SA, SA Health, May 2009.

APPENDIX 3

Supervision feedback form example

This form is designed to help you, your team and the service as a whole to get the most from your clinical supervision.

Frequency of supervision sessions:

Do you have an agreed documented supervision contract with your supervisor? Yes / No

Are your supervision goals and objectives being met? Yes / No

In what way are / aren't these goals and objectives being met?

What are the most useful aspects of your supervision?

What expectations are not met from your supervision?

Do you have any additional comments about your supervision?

Source: Area Nursing and Midwifery Services Policies and Procedures, Clinical Supervision Policy 2007/01 cited in South Eastern Sydney Illawarra area procedure, Clinical Supervision – Podiatrists, September 2008.

APPENDIX 4

Supervision session outline example

Agenda/Structure/Content /Timing (approx)

Before session

1. Preparation

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

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

10 mins

2. Identifying and exploring

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

30 mins

3. Analysing

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

10 mins

4. Goal setting and action planning

The supervisor may demonstrate a particular treatment for a given situation or draw attention to a particular guideline or outcome measure and may suggest further information gathering through reading. Review of issues in conjunction with:

- Relevant theories
- Practice standards
- Quality indicators
- Developing ideas about how to incorporate Evidence Based Practice.
- Goal setting – problem solving and action plan to achieve goals. SMART goals (specific, measurable, achievable, realistic, timely).
- Link the discussion of goals to the last meeting. Assigning new issues to address. Identify short, medium and long-term goals
- and timeframes to achieve these goals - Tasks are identified to achieve goals.

10 mins

5. Summarising

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

Bring to next session

6. Reflection in practice

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

Source: Adapted from Clinical Supervision Programme and Procedures, Department of Nutrition and Dietetics, Central Hospital Network, South Eastern Sydney Illawarra Area Health Service (SESIAHS)

APPENDIX 5

Supervision log example

Date	Type/Length of session	Outcome

Source: Allied Health Clinical Support Framework, Country SA, SA Health, May 2009

APPENDIX 6

The ISBAR framework for communication

ISBAR is the NSW Ministry of Health accepted methodology for communicating about holistic patient care. Handover should always happen in line with ISBAR as shown below.

I	**Introduction** – Identify yourself, role, location and who you are talking to.	"I am (name and role), from (ward/facility) and I'm calling because (clear purpose)"
S	**Situation** – state the patient's diagnosis/ reason for admission and the current problem.	"The situation is that I have a patient (age/gender), who is (diagnosis/deteriorating/stable). My concerns are (clear and succinct concerns). The current presenting symptoms are (clear, current and relevant symptoms and observations)."
B	**Background** – what is the clinical background or context?	By way of background (Give pertinent information which may include: Date of admission / presenting symptoms / medication / previous recent vital signs / test results / status changes and any relevant medical history)
A	**Assessment** – What do you think the problem(s) is? (Don't forget to have the current vital signs and a key problem list ready!)	"My assessment on the basis of the above is that the patient is….. they are at risk of ... and in need of ..."
R	**Recommendation** – What are you asking the person to do?	"My recommendation is that this patient needs (what test/action) by (who) within (timeframe)." Repeat to confirm what you have heard, eg, "I understand that I am to ... and you will …"

You can find more information about ISBAR in the NSW Health Policy Directive 2009_060: "Clinical Handover – Standard Key Principles" (2009) and NSW Health Caring Together "Implementation Toolkit – Standard Principles for Clinical Handover" (2009).

APPENDIX 7

Self assessment tool

Minimum standards of patient care for adult inpatients

❑ Ward Assessment	❑ Staff member assessment
Assessment attended by:	Assessment of:
Date attended:	Assessment attended by:
	Date attended:

Legend for Self-Assessment: A=Always >91% U=Usually 76-905 S=Sometimes 66-75% N=Not performing <65%

Standard	Interventions	Self-Assessment A	U	S	N	Action Plan
STANDARD 1 Documentation and Communication	• Within 24 hours of admission, all patients will have a comprehensive assessment completed and documented					
	• All patients admitted to hospital will have a care plan developed and updated each shift by the nurse caring for the patient					
	• Changes to the care plan are communicated between nursing staff at the time of clinical handover					
	• Expected Date of Discharge (EDD) will be documented for all patients					
	• All discharges and transfers will be planned					
	• Relevant patient education is to commence on admission					
	• All patients will have a nurse responsible and accountable for their care at all times. If the patient's primary nurse leaves the ward, a patient handover must be provided to a nurse remaining on the ward who will provide ongoing care for the patient					
	• A clinical handover will be conducted between each changeover of shift and whenever the patient is transferred					
STANDARD 2 Privacy and dignity	• All patients will be treated with respect and dignity and all patients' information will be treated with confidentiality					
	• When performing nursing care of an intimate nature, attendance of a second staff member is to be considered					
	• Requests by patients to have family/carers involved in the delivery of care should be honored					
	• Same gender rooms will be facilitated within 24 hours of admission and patient's wishes					
STANDARD 3 Clinical Monitoring and Management	• On admission, all patients will have baseline observations attended including urinalysis, weight and height. Weight should continue to be recorded at least weekly					
	• Physiological observations to be attended at least 8 hourly, documented and acted upon					
	• Appropriate actions will be initiated to escalate care for deteriorating patients following local Clinical Emergency Response Protocols					
	• All patients will be observed by a nursing staff member a minimum of once every 60 minutes					
	• Standard infection control precautions will be adhered to including (PPE) and the five moments of hand hygiene					

Standard	Interventions	Self-Assessment A	U	S	N	Action Plan
STANDARD 4 Clinical Intervention	• All therapeutic interventions will be evidence based					
	• Patient care will be delivered by nurses according to their level of competence and scope of practice					
	• All admitted patients must wear a white patient identification band with patient's name, date of birth and unique identification number. If patient has had a known allergy or adverse event to medication, replace with red armband with patient's name, date of birth and unique identification number					
	• Patient identification will be verified prior to any intervention and on any transfer of care					
STANDARD 5 Preventing Risk and Promoting Safety	• All patients will have a manual handling risk assessment attended at least every shift					
	• Pressure area care will be attended a minimum of every 4 hours for patients who cannot change position independently					
	• All patients will have a mobilisation plan in place					
	• All patients with sensory aids (eye glasses and hearing aids) will have them fitted during periods of activity					
	• Low level lighting will be utilised during the night according to patient needs					
	• Patients' environment will be tidied / cleaned each shift and made devoid of clutter					
	• All patients will have a call bell within easy reach at all times					
	• Non-slip footwear will be placed on the patient prior to mobilising					
STANDARD 6 Personal Care	*As part of hygiene care, the following will be offered / attended during each 24 hour period:* • Shower or bed bath, eye care, ear hygiene, nasal care, mouth/teeth/ denture care, skin/nail care, hair grooming/washing, facial shaving (male), perineal care (all episodes of incontinence to be attended promptly to avoid perineal breakdown and patient discomfort)					
	• Patient's usual elimination habits are to be maintained and/or supported during their episode of care					
	• Incontinent patients will have a continence management plan					
	• Any patient requiring a fluid balance chart record must have all intake and output recorded i.e. IV, oral intake, urine output, wound drains					
	• All nursing staff to be available during patient meal times to assist patients with positioning, opening of packaging and feeding as necessary					
	• All patients requiring full feeding (nasogastric/PEG) or who are on a modified texture diet will have a food record chart and fluid balance recorded					
STANDARD 7 Medications	• Medication charts will be checked fourth hourly and medications will be administered according to the Five Rights of Medication					

Source: Self-Assessment Tool for Minimum Standards of inpatient care developed by Hunter New England Local Health District, 2012

References

1. Kirk S, Eaton J, Auty, L. Dieticians and supervision: should we be doing more, Journal of Human Nutrition and Dietetics, 2000; Volume: 13: 317-322.
2. Smith R, Piling S. Supporting the transition from student to professional – a case study in allied health, Australian Health Review; 2008; Volume: 32 :1.
3. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards. Sydney: 2011.
4. Australian Nursing Midwifery Council. National Competency Standards for the Enrolled Nurse. Sydney: 2002. <http://www.ahpra.gov.au/Search.aspx?q=competency%20standards>
5. Australian Nursing Midwifery Council. National Competency Standards for the Registered Nurse. Sydney:2006. <http://www.ahpra.gov.au/Search.aspx?q=competency%20standards>
6. Australian Nursing Midwifery Council. National Competency Standards for the Nurse Practitioner. Sydney:2006. <http://www.ahpra.gov.au/Search.aspx?q=competency%20standards>
7. Australian Nursing Midwifery Council. National Competency Standards for the Midwife. Sydney:2006. <http://www.ahpra.gov.au/Search.aspx?q=competency%20standards>
8. Australian Nursing Midwifery Council. Code of Professional Conduct for Nurses in Australia. Sydney:2006. <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx>
9. Australian Nursing Midwifery Council. Code of Professional Conduct for Midwives in Australia. Sydney:2008. <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx>
10. Nursing and Midwifery Board. Code of Ethics for Nurses in Australia. Sydney:2008. <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#codeofethics>
11. Australian Nursing Midwifery Council. Code of Ethics for Midwives in Australia. Sydney:2008. <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.aspx#codeofethics>
12. Benner P. From novice to expert: Excellence and power in clinical nursing practice. Menlo Park, USA : Addison-Wesley, 1984: 13-34.
13. Walker M, Peyton JWR. Teaching in theatre. In Peyton JWR, editor. Teaching and learning in medical practice, Rickmansworth, UK:Manticore Europe Ltd., 1998: 171-180.
14. World Health Organization. Framework for Action on Interprofessional Education and Collaborative Practice. Geneva, Switzerland, 2010. < http://www.who.int/hrh/resources/framework_action/en/>
15. Irwin J. Professional practice supervision workshop: workshop handouts. Faculty Education and Social Work, University of Sydney, 2008.
16. Nightingale F. Notes on Nursing: What it is, What it is not. New York: Appleton and Company, (First American Edition) 1860. < http://digital.library.upenn.edu/women/nightingale/nursing/nursing.html>
17. Kitson A, Harvey G, McCormack B. Approaches to implementing research in practice. Quality in Health Care, 1998: Volume: 7, 149–159. <http://onlinelibrary.wiley.com/doi/10.1111/j.1741-6787.2007.00073.x/full>
18. Kitson A, Rycroft-Malone J, Harvey G, et al. Evaluating the successful implementation of evidence into practice using the PARiHS framework: theoretical and practical challenges. Implementation Science 2008; Volume: 3:1. <http://www.implementationscience.com/content/3/1/1>
19. HCPro Inc. Nurse Preceptor Program Builder. What is Preceptorship?, 2nd Edition 2007:1:1-6. <http://www.strategiesfornursemanagers.com/supplemental/5527_book.pdf>
20. Bain L. Preceptorship: a review of the literature. Journal of Advanced Nursing, 1996; Volume 24: 104-107. < http://onlinelibrary.wiley.com/doi/10.1046/j.1365-2648.1996.15714.x/>
21. Kramer N. The Reality Shock: Why Nurses Leave Nursing. Mosby, St Louis, Missouri, USA, 1974.
22. Smedley A, Penny D. A partnership approach to the preparation of preceptors. Nursing Education Perspectives 2009: Volume 30:1:31-36
23. Schaubhut RM, Gentry JA. Nursing preceptor workshops: partnership and collaboration between academia and practice. Journal of Continuing Education in Nursing 2010; Volume: 41 (4): 155-160.
24. Eley S. The Power of Preceptorship, RN Journal, 2013 <http://rnjournal.com/journal-of-nursing/the-power-of-preceptorship>
25. Barr F. Nursing peer review: Raising the bar on quality. American Nurse Today 2010; Volume: 5: 9 <http://www.americannursetoday.com/article.aspx?id=7078#>
26. Haag-Heitman B, & George V. Nursing peer review: Principles and practice. American Nurse Today 2011; Volume: 6: 9. <http://www.americannursetoday.com/Article.aspx?id=8244>
27. Greene J, Grant A. Solution-focused coaching: Managing people in a complex world. London, UK: Momentum Press, 2003.
28. Grant AM, Curtayne L, Burton G. Executive coaching enhances goal attainment, resilience and workplace well-being: a randomised control study. The Journal of Positive Psychology, 2009; Volume: 4: 5: 396-407.
29. NSW Ministry of Health. HETI Coaching Module. Sydney: NSW Health, 2013 <http://nswhealth.moodle.com.au/login/index.php>
30. Griffiths K, Campbell M. Regulating the regulators: Paving the way for international, evidenced based coaching standards. International Journal of Evidence Based Coaching and Mentoring 2008; Volume:6:1.
31. Whitmore J. Coaching for Performance: GROWing Human Potential and Purpose - The Principles and Practice of Coaching and Leadership. London, UK: Nicholas Brealey Publishing, 2009.
32. Grant A. Developing an agenda for teaching coaching psychology. International Coaching Psychology Review 2011; Volume: 6 : 1: 84-99.
33. NSW Department of Health. Early Package - maternal and child health primary health care policy. Sydney: NSW Health, 2009. <http://www.sfe.nswiop.nsw.edu.au/file.php/1/NSWHEALTH_SFEmaternal_ChildHealth.pdf>
34. NSW Department of Health. Professional Practice Framework for Child & Family Health Nurses 2011-2016. Sydney: NSW Health, 2011 <http://www0.health.nsw.gov.au/pubs/2011/pdf/cfhn_report_web.pdf>.
35. Davys A, Beddoe L. Best Practice in Professional Supervision: A guide for the helping professions. London, UK: Jessica Kingsley Publishers, 2010.
36. Driscoll J. Practising Clinical Supervision: a reflective approach for health care professionals, 2nd Edition. Edinburgh,UK: Bailliere Tindall Elsevier, 2007.
37. Bond M, Holland S. Skills of Clinical Supervision for Nurses. Birmingham, UK: Open University Press, 1998.
38. Consedine, M. Using Role Theory in Clinical Supervision, Australian & New Zealand Psychodrama Association Journal 2001; Volume: 10: 37-49.
39. Winstanley J, White E. Clinical supervision: models, measures and best practice, Nurse Researcher, 2003; Volume: 10: 4: 7-38.
40. Carroll, M. One More Time: What is Supervision? Psychotherapy in Australia 2007; Volume: 13: 3: 34-40.
41. Edwards D, Cooper L, Burnard P, et al. Factors influencing the effectiveness of clinical supervision. Journal of Psychiatric and Mental Health Nursing 2005; Volume: 12: 4: 405-414.
42. Marsick V, Maltbia T. The transformative potential of action learning conversations: developing critically reflective learning skills. In Mezirow, J. & Taylor, E. (Eds) Transformative learning in practice: Insights from community workplace, and higher education. Jossey-Bass, San Francisco, 2009.
43. Fox R. Relationship: The cornerstone of clinical supervision. Social Casework: The Journal of Contemporary Social Work 1989; Volume:70: 3:146-158.
44. Wilson HS, Kneisl CR. Psychiatric Nursing 5th Edition, Benjamin-Cummings Publishing Company 1999.
45. Te Pou. National Guidelines for the Professional Supervision of Mental health and Addiction Nurses. Auckland: Te Pou, The National Centre of Mental Health Reasearch, Information and Workforce Development, 2009.

Appendices

Allied Health Clinical Support Framework, Country SA, SA Health, May 2009

Area Nursing and Midwifery Services Policies and Procedures, Clinical Supervision Policy 2007/01 cited in South Eastern Sydney Illawarra Area procedure, Clinical Supervision – Podiatrists, September 2008.

Clinical Supervision Programme and Procedures (Adaptation), Central Hospital Network, South Eastern Sydney Illawarra Area Health Service, Department of Nutrition and Dietetics.

Doran GT. There's a S.M.A.R.T. way to write management's goals and objectives. Management Review 1981; Volume: 70: 11: 35-36.

NSW Health Policy Directive 2009_060: "Clinical Handover – Standard Key Principles" 2009 and NSW Health Caring Together "Implementation Toolkit – Standard Principles for Clinical Handover" 2009.

Port Augusta Hospital and Regional Health Service, cited in Allied Health Clinical Support Framework, Country Health SA, SA Health, May 2009.

Self-Assessment Tool for Minimum Standards of inpatient care developed by Hunter New England Local Health District, 2012

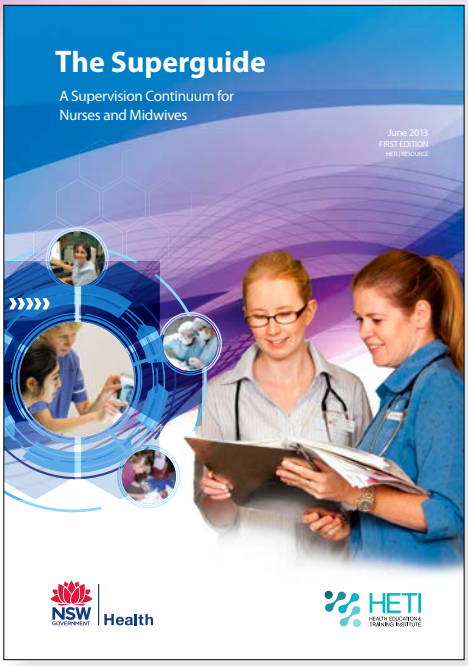
Notes

The Superguide

A Supervision Continuum for Nurses and Midwives

HETI has produced this guide in response to the identified need for improved clinical supervision at the point of care. This guide is focused on practical advice to improve the effectiveness and educational value of clinical supervision.

We hope this guide will be useful to nurses and midwives who undertake supervision. This guide is not a policy document. It gives tips and suggestions on how to undertake supervision.



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