

Supervision in Healthcare: A Critical Review of the Role, Function and Capacity for Training

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Abstract This paper examines the notion of clinical supervision and takes a close look at what it means from the perspective of both the supervisee and the supervisor, considering how it can be of benefit to the learner, the teacher and the patient. Clinical supervision has been shown to be vital for the development and consolidation of undergraduate and postgraduate education, while having a positive impact on patient outcomes and as such is a fundamental component in healthcare education. Central to supervision is achieving the best outcomes for the supervisee, and effective supervision ensures the development of confidence, professional identity, and the consolidation of therapeutic knowledge. Clinical supervision provides a platform for extending the supervisor-supervisee relationship beyond the student-teacher model to one of mutual personal development in contemporary knowledge and skills for clinical practice. Despite the perceived importance of clinical supervision for healthcare more broadly, there is evidence to suggest that few supervisors are adequately prepared with the theory and practice of clinical supervision to adequately fulfill the expectations that the role entails. It follows therefore, that in many cases, there is an expectation that the health professionals will supervise without adequate preparation. This paper, although not a panacea, may assist those who are supervising and who seek or require some guidance and support.

Keywords Education, Healthcare, Mentor, Role model, Student, Supervision

1. Introduction

Before we can begin to unpack the nuances of clinical supervision for effective implementation, it is essential to understand what is meant by supervision in healthcare,

and the many differing names, definitions, functions and models. At the centre of this still unsettled nature of supervision, as an entity, is a recognition that supervision is one of the least developed facets of education, having only a limited empirical or theoretical basis.[1-3] While the term ‘clinical supervision’ adopts many aspects of precepting and mentoring, and is often used interchangeably, the roles or models of supervision are quite different.

Within the literature, definitions of supervision have evolved both within higher education and within healthcare.[4-13] For example, supervision has been described as either a one-way process or a two-way process with joint endeavour, consultation, working alliance at its core.[14-18] Further, it is often outlined to be a formal activity for professional development and learning where there is an emphasis on discussion, feedback, guidance and support with the aim of enhancing the functionality, quality, and capability or effectiveness of the supervisee.[14-18]

Looking beyond the definition, to the models of supervision – particularly those in medicine – it is evident that the apprenticeship model remains dominant. As such, this model is framed by “a clinical apprenticeship of the novice to the master craftsman”.[19] It is where a more experienced health professional guides and ensures that the subordinate or less experienced supervisee is exposed to and provided with opportunities to develop their clinical competence, to become more independent in practice.[20, 21]

However, others challenge the apprenticeship model and suggest that it is inconsistent with the principles of adult-learning theory and sociocultural learning, that are founded on theories of applied learning with an emphasis on isolated experiential learning and reflective practice.[19] The lack of emphasis on adult learning principles in the apprenticeship model means that training physicians receive limited or no training in this area, a

finding that Senediak and Bowden [22] attribute in part to concerns that the incorporation of these best-practice approaches to teaching and learning might expose the current apprenticeship model as being less than the gold standard.

As well as those in medicine, other models of supervision can be found in literature from other discipline areas such as nursing, social work, and counselling.[2-10] For example, there are models such as ‘narrative-based supervision’, ‘incidental supervision’ and ‘peer supervision’ each of which has their own idiosyncrasies. All of this would suggest that definitional consistency and models of supervision – even within each health discipline – remains elusive.

To fully appreciate the diverse nomenclature, definitions and models of supervision in healthcare, a critical review of the literature sought to identify and examine supervision definitions and models.[23] As such, the aim of this review to examine the notion of clinical supervision and what supervision means from the perspective of both the supervisee and the supervisor, considering how it can be of benefit to the learner, the teacher and the patient.

2. Materials and Methods

2.1. Search Strategy

A broad literature search was conducted in March 2019, using Medline, CINAHL, PsycINFO, Informit, JSTOR, Science Direct, Scopus and Web of Science databases to identify supervision definitions and models used in literature discussing supervision within healthcare professions including nursing, allied health and medicine between 1999 and 2019. The databases were accessed using title, keyword, or abstract and then full-text. Search terms included “Healthcare” AND “Supervision” OR “Preceptor” OR “Apprentice” OR “Mentor” including word suffixes. This strategy was used to search title and abstract in all databases and was adapted to the specific requirements of each database. Additional searches of literature were conducted by hand searching or reviewing reference lists.

2.2. Inclusion and Exclusion Criteria

The reviewed studies included those that were original research or peer reviewed commentaries on the subject. Inclusion included both internal and external to the acute hospital settings and included all healthcare professions where the supervisee was a student or novice healthcare professional. Studies were excluded if their focus was solely on program evaluations, measuring the efficacy or impact of supervision models, or were discussions informing government policy. However, studies were

included if they focussed on seeking or discussing supervision taxonomy, models and their relative strengths and weaknesses. Full-text articles published in languages other than English were not reviewed given the issues associated with translation qualities.

2.3. Study Screening

The articles retrieved from the search were exported to EndNote (version X7) and screened by two reviewers (DT and BP) after duplicates were removed. Both reviewers independently screened all studies based on titles, keywords and abstracts to exclude irrelevant articles. In the second round, full text articles were assessed independently and judged against the inclusion and exclusion criteria by two reviewers (DT and BP). Each study was classified as ‘include’, ‘exclude’ or ‘not sure’ in the review. Any discrepancies between the two reviewers were resolved by discussion with a third reviewer (AP) until consensus was achieved.

3. Results

The literature search resulted in a total of 5,779 records. After 791 duplicates were removed, there were 4,988 potentially relevant records. The subsequent title and abstract screening led to the exclusion of 4,781 records. A total of 207 full-text articles were assessed for eligibility against the inclusion and exclusion criteria, resulting in 149 studies being further excluded. Finally, 58 original research studies were included where the necessary data were available. The majority of studies focussed on Nursing (n=26) and Medicine (n=22) followed by Psychiatry (n=4), Physiotherapy (n=2), Social work (n=1), Pharmacy (n=1), and Occupational therapy (n=1), with the remaining examining supervision in non-specific Allied Health professions (n=2), as outlined in Figure 1.

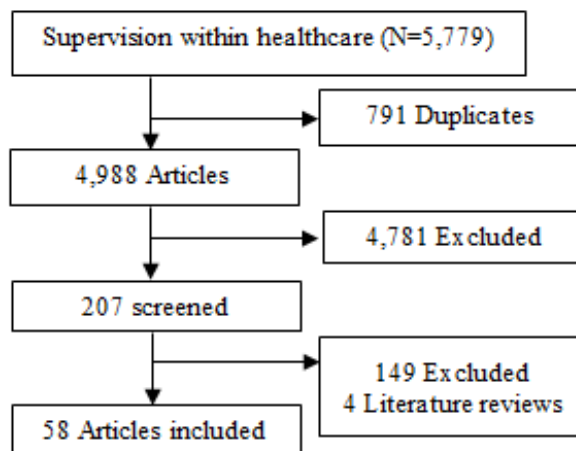


Figure 1. Literature search results

Table 1. Contemporary definitions of supervision

| Authors, Year | Description or Conceptualisation | People and Setting | Focus, Method and Process | Aims, Goals |
|--|---|--|--|---|
| (Bernard & Goodyear, 2008) [4] | An intervention | Provided by senior members of a profession to a more junior members of the same profession | Is evaluative and extends over time | To enhance the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients, and gatekeeping those who enter the profession |
| (Barker, 2006; Cutcliffe & Butterworth, 2001) [5, 6] | A formal process of professional support and learning | To enable individual clinicians | - | To develop knowledge and competence and assume responsibility for their own practice |
| (Hancox & Lynch, 2002) [7] | A formal process of consultation | Between two or more professionals | To provide support for the supervisees | To promote self-awareness, professional development and growth in their professional environment |
| (Hawkins, Shohet, Ryde, & Wilmot, 2012) [8] | A joint endeavour | A supervisor will help a supervisee attend to their clients the wider healthcare context | - | To improve the quality of student's/novice's work and develop their practice and the wider profession |
| (Chaves et al., 2017; Inskipp & Proctor, 2001) [9, 10] | A working alliance | Between supervisor and supervisee | Supervisee accounts or records their work; reflects on it; receive feedback and guidance | To enable supervisees to gain competence, confidence, compassion and creativity to give their service to the client. |
| (Kilminster & Jolly, 2000) [2] | Provision of monitoring, guidance and feedback | In the context of patient care | The ability to anticipate strengths and weaknesses in clinical situations | To maximize patient safety |
| (Martin, Kumar, & Lizarondo, 2017) [59] | A formal professional support process that is structured and planned. | Involves a supervisor and a supervisee in the workplace | Involves evaluation, reflective thinking and discussion about professional development, clinical issues and interpersonal issues encountered | To assist with the skill development of the supervisee |
| (Fernandez, Sheppard-Law, Curtis, Bancroft, & Smith, 2018; Hesketh & Laidlaw, 2003; Milne, 2007) [11-13] | A mutually beneficial education relationship based on trust, communication, respect and cultural influences | By approved supervisors, and work focussed | Uses corrective feedback on performance, teaching, and collaborative goal-setting | To manage, support, develop and evaluate colleagues. The objectives are about quality control, encouraging emotional processing, and maintaining and facilitating competence, capability and effectiveness. |
| (Hilli, Melender, Salmu, & Jonsen, 2014) [60] | A caring relationship as the foundation for student learning | Between supervisor and supervisee | Not only a cooperative relationship, but also has an ethical dimension. Needs to be a supportive environment for both the students and preceptors. | The focus is more than technical skills, but is an opportunity to learn personal skills in clinical judgement and ethical aspects of nursing. |
| (Carlson, Pilhammar, & Wann-Hansson, 2010; O'Keeffe & James, 2014) [39, 61] | Role modelling of the profession | Involves a professional in as a supervisor and a supervisee in the workplace | - | To develop 'competence, creativity, confidence and compassion' and benefits patient care. Other objectives are frequently included within the scope of professional supervision. |
| (Chun, Sosik, & Yun, 2012; Pack, 2009) [21, 45] | A developmental process | The supervisee learns the skills and confidence from supervisor | A more experienced mentor and a less experienced protégé are matched | To increase independence and to share organizational knowledge and career advancement. |
| (Senediak & Bowden, 2007) [22] | A reflective practice | Between supervisor and supervisee | Competency-based with a focus on skill development | To develop competent trainees and enhance clinical care, independence and ongoing development of skills and knowledge, with a commitment to life-long learning. |

Table 2. Supervision models in healthcare

| Author | Model | Discipline | Approach | Strengths | Weaknesses |
|--|---|---|---|---|---|
| (Launer, 2013; Morrison & Halpern, 2012a) [14, 15] | Narrative-based supervision | Medicine | A method for discussing complex and challenging medical cases with peers and trainees | Less prescriptive, unstructured, can be one-to-one or as a group. Can include the patient. | Less defined. Supervision means any conversation between professionals aimed at improving clinical care |
| (Undrill, 2012) [62] | Incidental supervision | Medicine | A flexible and opportunistic method of supervision that is and imbedded within practise. It has immediate impact without impacting clinical practise. Can be used in one-on-one and groups supervision. | Needs to be well structured using a formalised approach and used by those with skill and experience. | Can be difficult to recognise as more than being told what to do. Need to ensure it is adequately provided in meaningful way. |
| (Andersen et al., 2019; Kalisch, Falzetta, & Cooke, 2005; Miller, Miller, Burton, Sprang, & Adams, 2003) [16-18] | Telehealth supervision, Tele-mentoring, e-mentoring | Medicine Allied Health Psychology Nursing | A sustainable method for supervision among supervisees who are in rural and remote regions achieved through video link, email and other web based methods | Requires more formalised approach and set agendas. Can be achieved one-to-one or as a group and multidisciplinary. | Issues with technology and lack of personal contact or reduced time with supervisor |
| (Lekkas et al., 2007; Morrison & Halpern, 2012b; Tulinius, 2013) [63-65] | Peer supervision Balint method Reflecting teams | Medicine Allied health | Groups are focused on professional development, group sessions provide a systematic approach to the practice, based on a challenge or question that has created uncertainty in a group member. Groups are often geographically demarcated. | Focused around continuous discussion, social networking, and addressing uncertainty or an identified need. | A fluid process that is less systematic. Relies on uncertainty to facilitate learning, but does have provision for more systematic approach to learning. |
| (Davis, 2006; Kilminster & Jolly, 2000) [2, 66] | Client focused (or centred) supervision | Social work Occupational Health | Supervisors take on a facilitator role and trusts students to take responsibly for their own learning | Needs to be well structured. | Gaps in knowledge or impact on patient care may be challenging |
| (Severinsson, 1999) [67] | Ethical-oriented supervision models | Nursing | Model is a combination of management and counselling. Supervisees identify a problem, select relevant information, set priorities, develop action plan, analyse reactions, and evaluate strategies in the ethical decision-making process. | Can be quite defined, and although based on reflection and past practice remains theoretical. Focus is the development of cognitive skills. | Must have knowledge base and clinical standards to which profession must uphold |
| (Severinsson, 1999; Stainsby & Bannigan, 2012) [67, 68] | In-direct supervision | Nursing Medicine Allied health | Supervision or clinical observations are made by the supervisees, who later discuss their clinical experiences with supervisors who may or may not be on-site at all times. | Needs to be well structured. | Less defined, and may be problematic to resolve issues immediately. Gaps in knowledge of supervisor/supervisee may impact learning or patient care. |
| (Lekkas et al., 2007; Overton, Clark, & Thomas, 2009; Stainsby & Bannigan, 2012) [65, 68, 69] | Long-arm or role-emerging supervision | Allied Health | Off-site supervisors from the profession meet and discuss with supervisee regarding clinical experiences or practice only a few hours a week. On-site supervisors are from another health profession and assist with non-profession specific support. Additional profession-specific support may be provided. | Independence and autonomy of supervisees. Needs to be very well structured. Key goals and objectives delineated to ensure learning is achieved. | May be problematic to resolve issues immediately. Gaps in knowledge of on-site supervisor may impact learning or patient care. May not be suitable for novice supervisees. Cost may be prohibitive. |

| | | | | | |
|---|---|---------------------------|--|---|--|
| (Franklin, 2013; Franklin, Leathwick, & Phillips, 2013) [70, 71] | Preceptor model One-to-one model Group model | Nursing Allied Health | Supervisee or a group is assigned to a Supervisor. The supervisee(s) works alongside the supervisor day-to-day to provide direct and indirect supervision. Formative and summative assessments undertaken. | Defined roles and structures in place. Novice supervisees favour preceptor model. | Outcomes dependant on supervisor's clinical knowledge, skills and attitude towards supervisees. Increased clinic workload and time. |
| (Borch, Athlin, Hov, & Sørensen Dupplis, 2013; Franklin, 2013; Franklin et al., 2013) [70-72] | Facilitator or Group Model One-to-one model Group model | Nursing | Supervisee or a group is assigned to a Supervisor. The supervisee(s) works in conjunction with the supervisor and is provided more direct (one-on-one) and indirect supervision. Supervisor can be employed on casual basis and work across health facilities and in tertiary education. | Defined roles and structures in place. More proficient supervisees favour facilitator model. Better approach to link theory to practice and to reduce cost. | Outcomes dependant on supervisor's clinical knowledge, skills and attitude towards supervisees. More novice supervisees may be less suitable. |
| (Senediak & Bowden, 2007). [22]. | Apprenticeship model | Medicine Allied Health | Direct supervision with supervisee practising skills and performing tasks within an established supervisor | Defined roles and structures in place. Direct supervision of challenging or difficult supervisees. Essential for beginning or novice | Remains problematic if supervisee is situated in 'non-traditional' settings where health profession is not normally situated. May create reliance and dependency. |
| (Finnerty & Collington, 2013) [73] | Cognitive Apprenticeship model | Midwifery | Traditional models emphasise practical visibility of skills whilst cognitive models emphasise deliberate activities to assist thinking to surface and be made visible | The absences of the mentor initiating care and the student assisting, but that mentor is a mediator to demonstrate relevance of formal knowledge to practice. | Is focused on enhancing the development and higher cognitive abilities of learners. May be challenging for some students. |
| (Franklin, 2013; Franklin et al., 2013; Hesketh & Laidlaw, 2003) [13, 70, 71] | Mentor model | Nursing | Similar to preceptor model, however, less common among undergraduate supervisees. Can be a direct or in-direct approach | More indirect and requires a level of competency and independence among supervisees. | Requires longer term relationship between parties. Not well suited to short term supervision or undergraduates. |
| (Aston & Molassiotis, 2003) [74] | Peer support supervision model | Nursing | Senior students supervise and support junior students in clinical placement, while being overseen by clinical mentor | Uses communities of practice approach to supervision. Develops the senior and junior student capacity | Requires clinical mentor who is engaged with the process and address issues at short notice. Increased levels of responsibility among senior students. The capacity for poor performance/skills to remain unchecked. |
| (Russell, Hobson, & Watts, 2011) [75] | Team Leader Model | Nursing | Teams of three: a registered nurse as 'Team Leader' and supervisor, an undergraduate student and the third being a staff member who would benefit from additional support, such as graduate nurse | Uses communities of practice approach to supervision. Develops the novice and student capacity | Requires clinical mentor to be engaged with the process and address issues at short notice. Increased levels of responsibility for novice. |

Within the literature each definition of supervision was captured and is outlined in Table 1. Despite the diversity, for the purpose of this paper, the definition by Bernard and Goodyear [4] which has been widely accepted, is adopted to underpin the discussion of supervision.

An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients... [Supervisors are] serving as a gatekeeper for those who are to enter the particular profession. (p. 8)

In addition to the definition, the models of supervision are outlined in Table 2, highlight the type, strengths and limitations of each supervision approach, and confirms the apprenticeship model remains dominant, as previously discussed and outlined in Table 2.

Despite the supervision differences that are noted between and within professions, the following analogous and fundamental aspects of supervision were identified within the literature. These themes included the dynamic nature of the supervisory relationship; the challenges, recommendations, and actions for supervisors; the required elements of supervision, which include awareness, planning, communication, and modelling. Additional themes encompass moving from direct instruction to self-directed learning, which involves review, feedback and reflective practice, and are all discussed in detail.

3.1. The Dynamic Nature of the Supervisory Relationship

Although much of the available literature tends to focus on the 'best case scenario', supervision is a dynamic entity open to its inherent challenges. Pack⁷ identified that some of the more prevalent challenges include conflicts or 'clashes' between the personalities, and challenges to established and perhaps forming boundaries between the supervisor and supervisee that may at times involve the patient. Compounding this may be the hierarchical structures of the organisation as well as the differing expectations of the supervisory role that each party has. For example, supervisees may anticipate supervision as an educational and well supportive process, while supervisors may consider supervision being centred on novice inexperience and dependence. As such, Pack [21] suggested that the role of the supervisor, particularly in medicine, can and has led to the "pathologising of the supervisee".[21] This has resulted in the view that supervisees may be ill-equipped, regressive and dependant, with subsequent restrictions or reductions in supervisor feedback.[24]

The dynamics of the supervisory relationship are also

mediated by elements that may be considered external to the relationship, but have implication for their effectiveness. These elements include the level of training the supervisor may have, the provision of misleading or misguided information prior to clinical placement, or a change in the circumstance of external parties which trickles down to last minute changes in supervisee or supervisor participation in the planned engagement. At the same time other elements which may have an impact include gender or cultural differences of various individuals.[6] It is these differences that may further exacerbate the supervisory encounter. For example, supervisees from different cultural backgrounds may be less likely to voice an opinion or indicate they do not understand. This can then lead to perceptions of poor knowledge or negative perceptions of the individual, or group of individuals – that they do not consult or discuss issues with the supervisor before proceeding with patient care.[21]

Another external variable that has been shown to have an effect on the supervisory relationship is the notion of timing. It is vital to recognise that as supervisees commence working with patients, they can experience anxiety regarding their own abilities or behaviours and how this may be perceived by the supervisor. It is a time of learning as the novice seeks to implement skills, learn what they are 'supposed' to do next, while interacting with and understanding the client. Despite these anxieties, beginning students and trainees are highly motivated as they are learning how to be a professional. However, as the initial anxieties abate, confidence increases, motivation is further moderated, and the autonomy of the individual further develops.[25] It is therefore poignant to work closely with and assist beginning supervisees to transition more effectively and efficiently through the period of anxiety, toward greater confidence and autonomy by harnessing their motivation and alleviating their fear.[3] Arguably it is the supervisor who has the greatest capacity to influence the relationship more broadly, however there may be some challenges.

3.2. Challenges, Recommendations and Actions

Clinical supervision does not occur in a vacuum, where the supervision of other staff would be the sole responsibility or concern within day-to-day practice. Instead, there are competing pressures of at times complex workloads, and the inherent costs associated with undertaking supervisory roles. At times, there may be an expectation from health facility, or registration body that some healthcare professionals will simply add the responsibility of supervision to their already under resourced roles.[12, 26] In addition, the added complexity of negotiating roles and responsibilities can leave a clinician – often a senior clinician – unsure of how to find a balance between patient care on the one hand and

supervision of junior staff on the other. Pack [21] captures this tension:

Supervisors can feel torn between the needs of the organisation, supervisees and clients. They endeavour to function as role models to supervisees yet struggle to establish an equal relationship in the process of [clinical supervision], as they are required to exert their authority to manage them. (p.664)

It is these challenges that may impact a supervisor's view of self and their capacity to effectively and meaningfully supervise, while balancing various competing responsibilities and interests. Added to this expectation and competing demands, there is the challenge of taking on the role with little or no training regarding effective supervision.

Overall, supervisors need to ensure supervisees develop their professional selves, be competent and confident in practice, while ensuring care can and is provided safely and adequately to patients. Not surprisingly, professional training of supervisors has been shown to improve and enhance outcomes, making the investment in professional training for supervisors a fundamental step in the development of clinically proficient supervisees.[25] Formalised training is all the more crucial when we consider the consequences of its absence. For example, supervisees who come to the supervisory encounter, may do so feeling ill-prepared and being reluctant to disclose that they may lack certain knowledge. This can also lead to working in isolation, working independent of the supervisor, and without continued consultation. This has the potential to lead to clinical errors, further impacting the supervisor-supervisee relationship and have a detrimental impact on patient outcomes.[12, 21]

Colleges, universities, and professional bodies recognise the importance of supervision training and implemented formalised supervisory training.[3] It is through these opportunities that clinicians collaborate with others and share experiences and best practice. Training also provides clinicians with contemporary literature and understanding to provide an opportunity for critical reflection and evaluation of one's own practice, and gives rise to peer review or external scrutiny of supervisory practices. [25]

The challenge is that health facilities may lack the resources, motivation, policies or capacity to provide effective support and training in these areas. There is a need to develop a culture where supervision and supervisory training is considered the touchstone of good practice, while developing an environment that pursues high or higher standards of effective clinical supervision.[3] The process needs both a 'top down' and 'bottom up' approach, where health professional's work with organisations to build a commitment to allocate appropriate time and resources to improve professionals' capacity to supervise. This in turn will have an impact on supervisees and lead to better patient outcomes.[3, 27] As

such, "the quality of clinical supervision is the key influence on the quality of the clinical placement and, ultimately, on the calibre of the health practitioner".[28]

Contemporary programs of education in Australia have led to an increasing number of healthcare professionals undergoing training to support an expanding healthcare system, with clinical practicum or work integrated learning being a key component of their preparation. Consequently, appropriate numbers of competent clinical supervisors need to be available to support students during clinical practicum, and suitable training must be available for clinical supervisors to develop and maintain their competency. In 2011, Health Workforce Australia (HWA) [29] developed the National Clinical Supervision Support Program, with a purpose to increase public trust in the education and training of health professionals, by using a coordinated and integrated approach to improve the capability and competency of clinical supervisors to effectively engage with supervisees.

The National Clinical Supervision Competency Resource [29] was subsequently established to be used both as a framework to guide and support health care providers to develop training programs in clinical supervision, and also as a tool to assess the competence of individual clinical supervisors. This placed the onus on the health service to deliver programs of education, targeting clinical supervision competency among their education teams, with the purpose being to build capacity and reform the delivery of education to trainees, and to meet future health workforce requirements across all locations and healthcare disciplines. The National Clinical Supervision Competency Resource also assists providers to identify and understand the core competencies and professional expectations of a clinical supervisor at two levels of practice: foundational and intermediate, thus providing a benchmark against which the learning needs of individual clinical supervisors, and organisation wide training requirements can be identified and assessed.[29]

3.3. Required Elements of Supervision

A number of key elements are required in order to develop the professional self, and to contribute to the enhancement of the supervisor-supervisee encounters.

3.3.1. Awareness of Self and the Other

The awareness of self and the other as a form of reflective practice factors within the supervisor-supervisee encounter, impacts on the outcomes of the overall transaction, where awareness of self and self-performance is the yard stick to measure overall development of skill and capacity to supervise, and remains at the centre of supervision.[6, 21, 30] Pack[21] further suggests a transactional analysis model is required to develop a structure and process that recognises micro level factors within a single encounter and over time. For example, the model considers the clients', supervisors' and supervisees'

socio-economic position, work setting, class, culture and ethnicity. The wider social systems of client and supervisor-supervisee and their employing agencies can be explored within this type of multi-level approach.[21] This multi-layered approach assists supervisors to recognise and pay attention to the supervisee's practice, their workload and case mix, while being aware of their psychosocial wellbeing, and the supervisor-supervisee relationship.[21]

As a supervisor, it is vital to recognise that supervisees come with a cacophony of learning, confidence levels, life experiences, and differing world views.[31] It is vital for supervisors to recognise this fact, and, to work with the resources – including personnel – that one has been given in order to assist and shape supervisees in a way that meets their professional development. In addition, supervision must also be of benefit to all parties involved – the supervisor, the supervisee and ultimately the patients in which they now, and in the future will encounter.[19]

3.3.2. Planning

Preparation and planning should be at the centre of each of the actions and processes, particularly within a supervisor-supervisee relationship. Central to the planning phase is to acknowledge that there are power imbalances in the relationship which include, but not limited to, status, knowledge and experience.[20, 22] These imbalances need to be explicitly discussed and negotiated both verbally, and if required, in writing. The development of a contract – verbal or written – will allow both parties to employ appropriate coping strategies and move forward as issues arise. Planning for a worst-case scenario is much like an insurance policy – being aware of obligations, and how to move forward if the need arises.[20, 22, 32]

Planning also includes a consideration of the 'who, why and how' the supervision itself is to be conducted in order to meet the needs of both parties, in an efficient manner. Planning is about gathering information both formally and informally, gaining insight into how others practice, and negotiating with staff around allocation, timeframes, and the needs of individual supervisees. Wickham [27] and Senediak and Bowden [22] have suggested asking a number of questions in the planning stage that will guide the practice of supervisors and improve the outcomes of the supervisor-supervisee encounters:

- Is there a local supervision policy? If so, does practice follow the policies?
- Is there a model of supervision that will or should be followed? If so, what does it entail and have both parties agreed on this model?
- Is there an opportunity to have a say in selecting a supervisee?
- Will supervisor-supervisee agree on and sign a contract and will it include a strategy to resolve any difficulties?
- How long will the relationship last?

- How many meetings are planned and of what length?
- What will be the ground rules for meetings, feedback and clinical performance review?
- How will meetings be recorded?
- Whose responsibility is the setting of an agenda for the meetings? Will the agenda include any preparatory reading?
- What tools will be appropriate within the supervision relationship?
- What are the goals outlined from the training organisation that are required to be met by the supervisee, supervisors or organisation?
- What roles does the supervisor undertake to ensure goals are met?
- How will the supervisor and supervisee measure the outcomes of supervision in order to demonstrate its impact on those who they service?

This list of questions is not prescriptive, but rather should be used to facilitate a supervisor-supervisee dialogue toward a better outcome for the encounter. It also provides the basis for other questions that may arise within a supervisor's repertoire over time. It is recommended that supervisors become fully cognisant of the key questions they would like answered before proceeding with supervision. Lastly, it is vital to revisit the discussion and any agreements made with each supervisee regularly to ensure that aims and goals are being achieved and to adjust or make changes when and if required.[21]

3.3.3. Communication

Communication is a vital element of supervision and several studies have highlighted the negative implications of failing to provide regular, effective feedback or the inability to communicate clearly and effectively.[27, 30, 33, 34] Along this line, effective communication will have a large impact on both the supervisor and supervisee. Rather than adopting a dictatorial approach to communication, it is more important to have open and fluid conversations and communication, so that it may not impede the process of teaching, learning, knowledge creation, and skill development. Communication, including regular feedback, ameliorates barriers between the supervisor and supervisee, as both parties come to the relationship with differing levels of power, expectations and also idealised versions of each other. It is through communication that facades or masks of perceptions are removed and both parties can come to understand each other as they really are.[21, 35] Communication opens opportunities for greater equability within the working relationship, where beliefs and values can be shared and respected.[6]

Communication opens a conduit between two parties that allows trust and respect to flourish. Without trust and respect, safety and security will be less likely to be felt by supervisees, which can impede the capacity for

supervisees to learn, develop and grow within their future workforce roles.[36] It has been highlighted that “without these preconditions of safety and trust, supervision is unable to be truly effective and becomes instead, disabling and restrictive”(p 663).[21] This does not mean there is a need for an interpersonal relationship outside the workplace; however, if this occurs both parties must be clear as to the boundaries and expectations that are set inside and outside of the working environment.[30]

Open communication should include the discussion of not only past successes, but also mistakes. It is through these discussions of one's own fallibility that greater learning and depth of appreciation can flourish. The process allows greater communication and knowledge seeking among supervisees, while it seeks to avert shame and ridicule that can create withdrawal, disconnection, and even resentment from the supervisee.[21, 30] This should not be seen as a time for confession of past misbehaviour, misdemeanours or gossip. Rather, this time should be used to highlight what has been learned through a supervisor's own errors and how this may be avoided. Potentially, past examples may be used as a learning opportunity by the supervisee that may otherwise make similar mistakes. Further, self-disclosure of successes and mistakes can assist supervisees to be self-reflective in practice, and is an essential or powerful skill for both parties to develop in their practice.[21] The communication process will need to be guided by a supervisor's own judgement of the situation, what can be learned, and in accordance with local policy and guidelines.

3.3.4. Modelling

While communication is vital, a supervisor's role modelling will have the greatest impact on the supervisee's learning 'professionalism'. Role modelling is the “intentional and explicit demonstration of professional behaviour during the course of everyday work; structured, reflective self-examination; and timely and meaningful evaluation and feedback for reinforcement” (p.138).[37] Often coined the 'hidden curriculum', it is through their implicit day-to-day interaction and observation of role models, being other more senior health professionals within a clinical environment, that supervisees develop as health professionals.[37-39]

The positive role model of a supervisor assists to develop professionalism among supervisees. It assists to shape who they will become as health professionals and impact career choices.[40] Positive role modelling should be a main focus among supervisors, raising the need for supervisors to learn to recognise positive behaviours and ways to best to role model these.[41] As supervisees see exemplary behaviours, they are more fully able to recognise their own behaviours and attitudes, which further assists positive changes in behaviour over time.[41] There are a number of core values that role models should

seek to emulate in developing a sense of health professionalism in their supervisee's and themselves. These are centred on patient care and include compassion, empathy, altruism and honesty. [42] Other key values include: clinical excellence, good teaching, acquiescence of values, professional demeanour, personal awareness and self-motivation.[43]

Role modelling is a much more complex social process than has been given justice here. However, in many cases, what we do, say, and how we behave is a more powerful way of influencing supervisees. [37, 40] There are a number of recommendations with implications across the various health professions. First, supervisors need to enhance their status as role models, which is centred on developing an awareness of role modelling and explicitly articulating their practice when interacting with supervisees. Secondly, supervisors must be acutely aware of the impact and enthusiasm they have on certain aspects of their role. Third, there needs to be adequate organisational strategies in place to support role modelling excellence and opportunities to develop greater capacity of self as a supervisor. Finally, there is a need for supervisors to communicate and collaborate with each other to develop their own role modelling skills.[40]

The time for 'learning from mistakes' and 'see one, do one, teach one' of role modelling is now long past, and effective supervision is a balance between appropriate oversight and clinical practice, while allowing adequate autonomy among supervisees.[44] For example, role modelling where supervisors remain physically or professionally absent within the health setting will be counterproductive. Similarly, supervisors who take on a significant direct patient care workload can also impede a supervisee's own autonomy and development.[44] The challenge is getting the balance between oversight, direct patient care and autonomy right; however, the process is dependent on patient safety as well as the capacity and capability of the individual supervisee.[45]

3.4. From Direct Instruction to Self-directed Learning

As previously outlined, supervision is a balance between appropriate and adequate oversight, clinical practice, and autonomy among supervisees, while being cognizant of patient safety and supervisee capacity and capability.[44] Goldszmidt, Faden [46] have suggested four supervisory styles, including (1) direct care supervision, (2) empowerment supervision, (3) mixed practice supervision, and (4) minimalist supervision. Each of these is based upon patient safety, supervisee clinical capacity and quality of care. Oversight and supervisory practice is initially more stringent and closely monitored depending on patient complexity and volume. However, as clinical competence and capacity of supervisee's increases, the reduction of supervision oversight occurs. For example, minimalist supervision is built upon high

levels of trust with capable supervisees and a greater delegation of patient care.[36, 46]

The ultimate goal of supervision is independent practice, and there remains a fine line between autonomy and care with supervisory oversight.[32, 47] Too much supervision impedes learner autonomy, while too much autonomy impacts clinical skill development and undermines patient safety.[48] Brydges et al. [49] have indicated that autonomy and supervision should co-exist, where autonomy can be provided, even when being supervised in practice. This approach has been shown to be more effective than 'unsupervised practice', where unsupervised practice may lead to inadequate developmental opportunities to increase competence and teamwork, that inefficiently prepares supervisees for the autonomy required and expected in the post training period.

The challenge is for the supervisor and supervisee to recognise a capacity to undertake greater levels of autonomy while not moving toward unsupervised practice. [50] It remains an ongoing process to ensure that the balance of autonomy and supervision is adequate. This balance is contingent on more than the supervisee's clinical knowledge and skills, and should include trustworthiness of the individual trainee.[36, 50] The dimensions of trustworthiness outlined by Kennedy et al. [50] include supervisees knowledge and clinical skills; their capacity to know their limits; the capacity to make adequate judgements; and being meticulous, reliable, truthful and dependable.

In an ideal world, supervision would run smoothly and issues or challenges would be minimised; however, it is vital to recognise challenges may arise along the way. In cases where supervision has provided more autonomous practice, supervisors may need to be acutely aware of key triggers to reassess a supervisee's progress and adjust autonomy and the degree of supervision provided. These triggers for greater oversight may be issues that arise in clinical situations, issues or concerns being raised by other health care professionals, patients or family members of patients.[50] It is also crucial to acknowledge that supervisees themselves may have concerns for patient safety and other issues when working autonomously. Although they may not seek help or want to indicate that they feel out of their depth, it is vital that they are aware that they can approach supervisors or more senior staff for clarification and questions without fear of reprisal. In some cases, the supervisees themselves are able to know and recognise when they are not practicing safely.[48] Each issue or concern will need to be individually assessed against the supervisee's clinical competence, and how then to move forward together in terms of ensuring the appropriate balance between supervision and supervisee autonomy.[50]

3.4.1. Oversight Activities

This brings us to what Kennedy et al. [51] term as

oversight activities to ensure that the supervisee's autonomy, competence and clinical learning are achieved, while maintaining patient safety. Four types of oversight have been suggested to be undertaken at particular times of clinical supervision. These include:

- *Routine oversight*: Activities that are planned in advance and undertaken with the supervisor to ensure quality;
- *Responsive oversight*: Clinical activities that occur in response to supervisee- or patient-specific issues and can be requested or be triggered by performance;
- *Backstage oversight*: Activities where the supervisee may not be directly aware, but is to ensure clinical care is being provided within the supervisee's competence; and
- *Direct patient care*: Activities where a supervisor moves beyond oversight of the supervisee to be actively involved in providing care for a supervisee's patient.

These oversight activities create opportunities for flexible learning, while mitigating issues and challenges that inevitably come with greater autonomy and potential for poor clinical habits to develop, and where supervisees may overvalue their own competence to practice.[49] These activities also ensure that trust can be built and maintained within the supervisor-supervisee relationship, while maintaining a high level of patient care and increasing the responsibility and competence of the supervisee.[36]

In addition, these activities enable a supervisor to adequately examine and understand ongoing performance from the beginning right through to the end of the rotation or time with the supervisee.[36] It allows the opportunity to provide more accurate and clear formative feedback, and identify those areas that may require improvement. To achieve this, contact time needs to be adequate so as to ensure bilateral familiarity, open communication, and trust are built and maintained. As this is achieved, the working relationship becomes more fully formed and allows open and honest questioning and feedback to be provided, while mitigating concerns that may arise from constructive feedback.[36]

3.5. Feedback and Reflective Practice

Throughout supervision, reflective questioning and providing feedback remains essential and must be well planned. The process will help the supervisee identify their strengths and weaknesses in their practice, while developing their ability to move forward and achieve new and revised goals.

3.5.1. Feedback

There has been some apprehension around providing questioning and feedback to supervisees.[22] For some supervisors, particularly those with little formal training,

providing feedback to supervisees about clinical practice or professional behaviour that is below the expected level of performance, can be construed as confronting or what some might term 'nerve-racking'. [21, 22, 52] Supervisors may fear the supervisee's reaction to such feedback, leading to fear of litigation or supervisee complaints and this can impact how and if adequate reflective questioning and feedback is given. As such it is imperative that open communication, both written and verbal, includes discussions about the supervisor's motivations for providing feedback, to ensure that the supervisee receives feedback adaptively and is open to participating in a plan for improvement. Again, if issues arise, the initial planning should resolve many of these issues. However, additional planning may need to occur through the process, whether this is with human resources, training bodies, or local and national bodies. This will all depend on circumstances and the situation. [21, 22, 52]

The supervisor should take confidence that reflective questioning and providing feedback is for the benefit of the supervisee, their future practice, and overall for all future patient care outcomes. Feedback can take many forms and the way feedback is provided is important, such as clearly and constructively articulating the issues, challenges and what worked well can have considerable impact on what can be learned by the supervisee. [35, 53] It has been suggested that clear, well thought out, and explicit formative feedback on a regular basis is preferred by supervisees and a much more powerful motivator for change and confidence in practice. [21, 52]

There are a number of definitions and variations of what feedback is and actually means within the clinical setting. [54] The 'formative' nature of feedback adds an additional layer of complexity in terms of how feedback may be characterised and what it actually means. It is argued that formative feedback and formative assessment is central to healthcare education and concerned with channelling trainees and students towards meeting expected performance goals. [55]

From an academic viewpoint, formative feedback is "information communicated to the learner [if delivered correctly] that is intended to modify his or her thinking or behaviour for the purpose of improving learning" (p.154). [52] In clinical practice formative feedback has been less clearly defined with no delineated best practice on how it can be achieved [56]; however, feedback within the clinical setting has been suggested to be at least "specific information about the comparison between a trainee's observed performance and a standard, given with the intent to improve the trainee's performance" (p.193). [54]

Formative feedback in the clinical setting may take on a number of features that include being on-going, two-way, meaningful to the situation, be credible, be highly specific, include self-assessment, while providing direction for improvement for the supervisee. [53] The approach used

may include oral feedback, individual and group debriefing, reflective reporting, and written reporting, or any combination of these depending on the needs of the supervisee at the time of the feedback. [57] It is through this formative approach that learning can occur, where practice can be altered and improvements are made by both the supervisee and the supervisor. Regardless of the numerous definitions and meanings, supervisors need to determine how and what works for their situation and then to be consistent throughout the trainee's or student's practice.

Feedback can be provided through the regularly planned meetings, where both parties are aware of the agenda and what will be discussed. It is vital these regular meetings use a formative or modifying approach. However, formative feedback can be at any time and, depending on the situation, may be best provided at the time of practice, clinical examination or shortly thereafter, rather than much later after the opportunity to teach has arisen. Other feedback opportunities may be less formalised and may be facilitated or encouraged. For example, peer feedback has been indicated to be a powerful motivator for learners. [55] Supervisors will be aware when these feedback approaches are appropriate, and it is vital to exercise judgement and sensitivity to ensure learning is maximised with the approach that is taken.

3.5.2. Reflective Practice

Reflective practice may be encouraged as part of the feedback process, whereby supervisees provide their supervisors with daily written reflections of their practice. Supervisees' reflections and self-appraisals give the supervisors a benchmark to assist in the formulation of high-quality feedback, increasing the likelihood that regular feedback will be provided to their supervisees. [58] This process of reflective practice and self-appraisal also ensures that students benefit by playing an active role in seeking feedback from the supervisor.

Overall, it is through continual formative feedback that supervisors gain an appreciation of how well the supervisee has developed. Through these processes one can ensure that summative or more final assessments are easily made, and a more accurate representation of the supervisee's performance and development over time is determined and/or articulated. [22]

4. Conclusions

This work represents a critical review of the available literature concerning clinical supervision in an effort to fully appreciate the diverse nomenclature, definitions and models of supervision in healthcare. The definitional challenges suggest that the search for a single definition that is appropriate for each clinical setting, specialist

discipline, and is able to inform the various models of clinical supervision that are common in practice is foolhardy. Instead, we suggest that the policy framework that surrounds models of clinical supervision should be informed ultimately by the development of confidence, professional identity and the consolidation of best practice, to ensure patient safety and the best outcomes for the supervisee. While acknowledging that the dynamic nature of clinical supervision means that it is rarely without its challenges, this critical review culminates in the recognition of those key elements required for successful clinical supervision.

Recognising that healthcare services have limited funds to support clinical supervision initiatives, we propose a series of insights distilled from this work that are recognised as central elements of effective clinical supervision that can be easily incorporated into already developed programs. Reflective practice is central to successful clinical supervision models. Providing a supported space for supervisors to recognise the influence of the 'non-tangible' personal characteristics of the interlocutors in the supervision relationship is essential. Becoming aware of the Self and other, and bringing to conscious awareness those micro factors, such as cultural, social background, and inherent idiosyncrasy in each supervisee, will provide a basis for recognising workload pressures, case-mix and for being aware of psychosocial wellbeing of the supervisee through the supervisee-supervisor relationship. Equally, self-reflection is central to the recommendation of professional role modelling behaviours, as well as the review and feedback process.

In the former, the supervisor reflects on and recognises the influence that their behaviour has on the development of the supervisee and in the later informs the capacity of the supervisor and supervisee to identify areas that are open to personal and professional development as well as strategies to address them. Recognising the power imbalance inherent within the supervisor – supervisee relationship and working to overcome it through self-reflection paves the way for constructive, open communication that is empowering for both parties. Developing a shared plan with agreed aims and objectives, timelines and expectations was found to be a key indicator of the overall success of the clinical supervision relationship. The agreed plan forms the touchstone for the supervisor and supervisee to come back to for informing periodic review and feedback. In culmination, having a plan that is agreed upon, that has strategic points for review and feedback, as well as a mechanism for identifying aspects of success will support the supervisor-supervisee relationship to progress from one of dependence to one of independence.

The principles of clinical supervision as a vehicle for the personal and professional development amongst healthcare professionals are enmeshed in the fabric of

contemporary healthcare practice. The outcomes from this close exploration of current 'best practice' would suggest that the development of a policy base that mandates the development of an agreed plan that has points of contact between the supervisor and supervisee, inclusive of, structured opportunities for review and feedback, will provide a trajectory for health agencies to pursue that does not impose further on the fiscally constrained sector.

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