Framework Document

Clinical supervision framework for ACT nurses and midwives

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Acknowledgement of Country

The Health and Community Services Directorate acknowledges the Ngunnawal people as traditional custodians of the ACT and recognise any other people or families with connection to the lands of the ACT and region.

We respect the Aboriginal and Torres Strait Islander people, particularly our Aboriginal and Torres Strait Islander staff, and their continuing culture and contribution they make to the Canberra region and the life of our city.

We also acknowledge that reflective practice holds deep significance in Aboriginal and Torres Strait Islander cultures. We honour these traditions and recognise their foundational role in shaping meaningful, culturally grounded, and responsive clinical supervision.

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Review Date

The next review of this document is due by 31 March 2029.

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Framework Statement

All ACT nurses and midwives have access to effective clinical supervision (CS) as a core component of professional practice and development.

Purpose

To enable the implementation and sustainability of effective CS that focuses on professional development and support for nurses and midwives.

To provide a foundational structure across ACT health services to support CS best practice, CS governance, and guide development and review of CS policy and guidelines.

To provide a shared understanding of CS and the roles and responsibilities within it, to enable the promotion of CS and awareness of operational and resource requirements.

To support standardised evaluation of CS effectiveness for nurses and midwives, implementation processes and the impact of CS through continuous quality improvement activities and research.

To align CS principles with National Safety and Quality Health Service (NSQHS, 2021) Clinical Governance Standard and Communicating for Safety Standard.

Scope

The scope of the framework is to provide guidance for nurses, midwives and organisations on the implementation and sustainability of CS.

This framework may be applicable to other health professionals, internal and external providers of CS, and CS education and training providers.

Fundamentals of clinical supervision

What is clinical supervision?

The term CS can apply to several processes in nursing and midwifery practice, including point of care supervision and facilitated professional development (Heti, 2013). This framework will focus on reflective CS practice and is underpinned by the Position Statement: Clinical Supervision for Nurses and Midwives (ACM, ACMHN, ACN, 2019).

Clinical supervision is a formally structured professional arrangement between a supervisor and one or more supervisees.

It is a purposely constructed regular meeting that provides for critical reflection on the work issues brought to that space by the supervisee(s). It is a confidential relationship within the ethical and legal parameters of practice.

Clinical supervision facilitates development of reflective practice and the professional skills of the supervisee(s) through increased awareness and understanding of the complex human and ethical issues within their workplace.

ACM, ACMHN, ACN, 2019

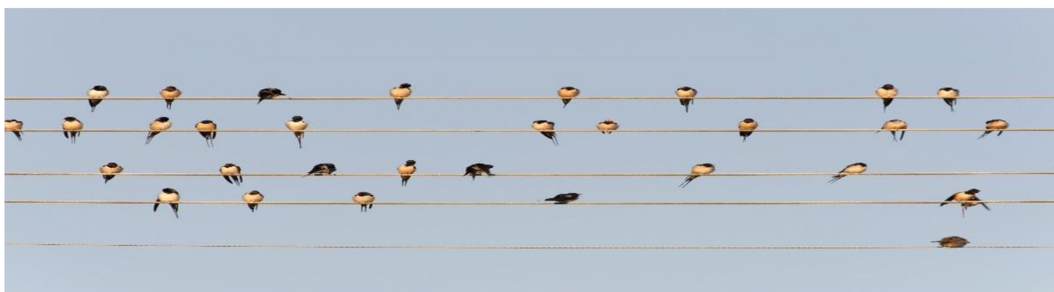
CS is an opportunity to discuss the challenges and rewards of nursing and midwifery practice with a trained supervisor. Supervisors guide reflective practice by asking curious questions to acknowledge achievements, examine work issues, and consider possible alternatives and future steps. Improving reflective practice skills increases the ability to practice with awareness and respond to workplace events effectively (Sharrock, 2021).

Who is clinical supervision for?

CS has been recommended for **all** nurses and midwives irrespective of:

- their role
- area of practice and
- years of experience

ACM, ACMHN, ACN, 2019



What are the benefits of clinical supervision?

Clinical supervision is increasingly recognised as a core component of professional support for contemporary nursing and midwifery practice. There is consistent evidence that effective clinical supervision impacts positively on the professional development as well as the health and wellbeing of supervisees. The health and wellbeing of nurses and midwives is vital for recruitment and retention and ultimately a healthy and sustainable workforce.

There is also emerging evidence that clinical supervision of health-care staff impacts positively on outcomes for service-users.

ACM, ACMHN, ACN, 2019

Benefits for supervisees

- supports nurses and midwives to find their own solutions and answers to practice issues
- supports the wellbeing of nurses and midwives
- facilitates the acknowledgement and management of occupational stress and burnout
- maintains professional boundaries
- provides role clarity and stronger sense of professional identity
- increases critical thinking skills.

Benefits for the organisation

- aligns with National Safety and Quality Health Service Standards (NSQHS, 2021)
  - Clinical Governance Standard
    - promotes best practice and professional accountability
    - strengthens workforce capability
    - provides structure of decision making
  - Communicating for Safety Standard
    - enhances team communication skills and cohesion
    - builds confidence in managing complex and/or sensitive conversations
    - reinforces practices that reduce errors

Benefits for consumers

- supports improved care delivery
- facilitates consistent standards of care.

Core principles of clinical supervision

This framework is underpinned by six integrated core principles (Figure 1; Table 1). These principles provide guidance for the successful implementation and sustainability of CS for nurses and midwives.

Figure 1: Six core principles of CS

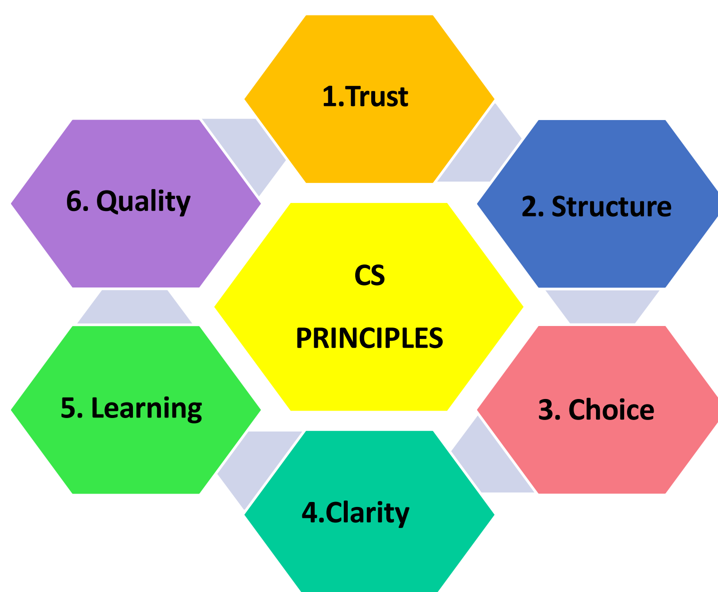


Table 1: Principles underpinning CS implementation and sustainability.

Trust	Development of a safe, trusting, supervisee and supervisor relationship is enhanced by a non-hierarchical, nurturing, inclusive and culturally respectful approach.
Structure	CS is a formal and structured process, underpinned by theoretical models that enable critical reflection and support.
Choice	CS is supervisee-led, with the overall goals and focus chosen by the supervisee, enabling tailored learning and support that is relevant and meaningful.
Clarity	The roles and responsibilities of supervisees, supervisors, managers and organisations are clearly understood and supported by organisational CS policy, guidelines and CS agreements.
Learning	Education about CS, continuous development of supervisors through experiential learning and their own CS, enables quality supervision.
Quality	Regular review of the supervisee and supervisor relationship, the effectiveness of CS for the supervisee, and implementation monitoring and evaluation, enhance continuous quality improvement.

Principle 1- TRUST

Development of a safe trusting supervisee and supervisor relationship is enhanced by a non-hierarchical, nurturing, inclusive and culturally appropriate approach.

A trusting alliance between the supervisee(s) and supervisor is the central element of effective clinical supervision. Clinical supervision is a culturally safe and respectful relationship that has commitment from both the supervisor and supervisee(s).

Clinical supervision has effective communication and feedback at its core; is supportive and facilitative.

ACM, ACMHN, ACN, 2019

The supervision relationship

Development of a positive and trusting supervisee and supervisor relationship is central to effective CS, and should include:

- a shared understanding of CS and the responsibilities within the supervisory relationship
- a strengths-based approach where the focus is on enabling and supporting the supervisee to be curious about their work, gain new insights, and apply new learnings to their professional practice
- the delivery of culturally safe and inclusive supervision that is responsive to the diverse needs of supervisees, and ensuring safe, respectful, and psychologically supportive engagement
- a shared responsibility for cultural safety within CS, applying equally to Aboriginal and Torres Strait Islander, and non-Indigenous clinicians, including reflective exploration of unconscious bias, power, and system-driven harm where relevant
- the adherence to confidentiality and professional boundaries in accordance with the Nursing and Midwifery Board of Australia (NMBA) Code of Conduct for Nurses and Midwives (2026)
- the development of supervision agreements between the supervisee, supervisor and managers that reinforce accountability, and outlines expectations, goals and boundaries
- supervisor knowledge, skills, and experience as a nurse and/ or midwife, with an understanding of the health system context
- the integration of all other principles which contribute to the building of trust within the supervisor relationship

A First Nations cultural lens within clinical supervision

Nurses and midwives who identify as Aboriginal and Torres Islander face many of the same challenges as the wider workforce, however these are frequently compounded by systemic discrimination and racism (Dept of Health, 2020). Understanding the impact of societal privilege and oppression is essential to managing power dynamics and building trusting and effective CS relationships. CS can provide a space to safely explore experiences of racism, cultural responsibilities and expectations, identity strain, and moral distress arising from system level factors. Within this space, supervisors facilitate reflective discussion that promotes insight, learning and validation, rather than problem-solving or justification of the system.

To facilitate culturally safe and respectful critical reflection, the supervision process must involve:

- an acknowledgement of colonisation and systemic racism, social, cultural, behavioural and economic factors which impact Aboriginal and Torres Strait Islander people
- an acknowledgement of cultural biases, assumptions, stereotypes and prejudices, and how these can impact supervision relationships
- an ongoing reflection on how to actively engage in allyship within the supervision relationship
- a pursuit to understand individual experiences of Aboriginal and Torres Strait Islander people, their strengths, needs and the need to avoid assumptions

(Safer Family Service, 2022)

Building cultural capability delivers broad workforce benefits. These capabilities enhance the capacity to recognise and respond effectively to diversity in all its forms, including culture, neurotype, sexuality, gender, reproductive health, and disability. Strengthening these capabilities within CS will improve the quality of supervision relationships by supporting culturally responsive reflective practice and contribute to a safer, more inclusive supervision environment.

The parameters of confidentiality

CS is confidential within the ethical and legal boundaries of nursing and midwifery practice.

ACM, ACMHN, ACN, 2019

Nurses and midwives have ethical and legal obligations to protect people's privacy, and is a fundamental component of CS. Therefore, a clear understanding of the parameters and boundaries of confidentiality is essential for supervisees, supervisors, managers and organisations.

If any potential areas of concern arise during CS, the supervisor should:

- carefully explore the concern with the supervisee to understand if there is a breach of safety or professional practice
- seek emergency care for the supervisee, supervisor and/or others as required
- seek guidance from their supervisor or another experienced supervisor (e.g., organisation CS Coordinator or supervisor training facilitator) as soon as practicable
- report concerns to the supervisee's manager as required with the supervisee's knowledge, and to Ahpra if the criterion for mandatory notification is met.

The supervisee is also responsible to act on concerns about unsafe or unethical practice of the supervisor. Supervisors are expected to practice within the professional codes of ethics and conduct for nurses and midwives (NMBA, 2022), and clinical supervisors (ACSA, 2017). Breaches of confidentiality, particularly when persistent and deliberate, may result in professional consequences, including loss of supervisory privileges, and/or notification to Ahpra (NMBA, 2022).

Mandatory reporting

While confidentiality is a priority in CS, discussions may arise that impact the health, wellbeing and/or safety of others. In these circumstances, the release of information is needed by law, legally justifiable under public interest considerations or is required to facilitate emergency care (NMBA, 2022).

Concerns that place the public at substantial risk of harm require a mandatory notification. These include:

- impairment
- intoxication while practising
- significant departure from accepted professional standards
- sexual misconduct.

(Ahpra, 2020)

Mandatory notifications can be made directly to the Australian Health Practitioner Registration Agency (Ahpra and National Boards) website.

Principle 2- STRUCTURE

CS is a formal and structured process, underpinned by theoretical models that enable critical reflection and support

Clinical supervision is predictable and consistent with thoughtful and clear structures, boundaries, processes, and goals.

The position statement does not preference a mode or model of clinical supervision as there is no evidence for the superiority of any approach.

ACM, ACMHN, ACN, 2019

Models of clinical supervision

CS is a formal and structured approach to reflection, involving self-reflection, rather than informal discussion or review without boundaries or recognised processes. Supervision-specific theoretical models, or models founded in psychotherapeutic approaches provide structure for the facilitation of CS towards new insights and learning that enable development of the supervisee's professional practice and personal development.

All models should assist the supervisee to question their practice and become increasingly self-reflective, considering the impact of personal values, assumptions, and beliefs on nursing and midwifery practice. Every approach must intentionally incorporate cultural awareness, and support diversity and inclusion.

Examples of process and developmental models used in CS:

1. **The interactive three-function model** (Proctor, 1986). Historically, this is the most utilised model for CS by nurses, sometimes referred to as the 'Proctor Model'. The model focuses on three core aspects:

    - **Normative:** developing the understanding of the professional and ethical requirements of the supervisee's practice.
    - **Formative:** developing the skills, understanding and abilities of the supervisee.
    - **Restorative:** developing the ability of the supervisee to cope with the emotional effects of their work

2. **The integrative model** (Hawkins & Shohet, 2012) is a process-oriented approach that integrates the relational and systemic aspects of supervision. The model is also referred to as the ‘seven-eyed supervisor model’ as seven areas are explored:

    - the topic/event identified for discussion
    - strategies and interventions used by the supervisee
    - relationships between those involved
    - thoughts and feelings of the supervisee
    - the supervision relationship
    - thoughts and feelings of the supervisor
    - thoughts and feelings of the team and/or organisation

3. The **What? So What? Now What?** (Borton, 1970) model provides a practical model for reflection through a cyclic approach. This model takes supervisees through 3 stages:
    - What? - The facts and details of the experience
    - So What? - Analyses and interprets the event/ circumstances
    - Now What? - Determining next steps

Modes of clinical supervision

Modes of CS depend on the number of supervisees engaged in each CS session, and how interactions in CS occur. Choice of mode is made in collaboration between the supervisor, supervisee and organisation. Influencing factors include access (e.g., physical space for face-to-face sessions), the best way to meet the learning needs of the supervisee, the experience level of the supervisor, and personal preferences.

CS sessions are either individual or group:

- Individual CS
  - one-to-one CS (1:1) where the supervisor facilitates CS for one supervisee
  - sessions are commonly for 1 hour per month (may vary in frequency).
- Group CS
  - the supervisor facilitates CS for two or more supervisees
  - recommended maximum of 4-6 supervisees to enable management of group processes
  - closed or open groups. Closed groups (same supervisees) aid the earlier development of trust and group functioning, while open groups (different supervisees) can improve access to CS for staff employed in shift-based positions
  - sessions are commonly for 1 – 1.5 hours per month (may vary in frequency)
  - the supervisor requires knowledge and skill to manage group processes and dynamics as well as facilitating the reflective process of CS. Training in facilitating a group is recommended
  - developed CS groups can provide an additional level of support and varied perspectives.

Individual and group CS can be offered in a face-to-face mode, via telephone, or virtually. All CS sessions should occur in a space away from the immediate work environment, where privacy can be maintained.

Although most CS is facilitated by the same supervisor on each occasion, 'peer supervision' is an option for experienced supervisees (who may also be supervisors). In this instance, the agreement may be for the role of supervisor to be rotated. CS is provided within work hours by a supervisor internal or external to the organisation. The supervisor may be from the same professional discipline as the supervisee(s) or from a different discipline. In either case, a shared understanding of CS for nurses and midwives as outlined in the position statement and the required knowledge and skills as a supervisor, are required.

Principle 3- CHOICE

CS is 'supervisee-led', with the overall goals and session focus chosen by the supervisee enabling tailored learning and support that is relevant and meaningful.

CS is focused on the work issues brought to the session by the supervisee(s).

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

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

ACM, ACMHN, ACN, 2019

Exploration and self-reflection in clinical supervision

CS enables reflection on any area in the professional domain of the supervisee's choosing, such as:

- clinical care including any uncertainties or learning needs
- experiences in the provision of care, positive and negative
- team functioning and communication
- professional development needs and options
- ethical dilemmas e.g., professional boundaries with consumers and health professionals
- interprofessional communication
- career development.

While CS is therapeutic, it is distinct from therapy, which is situated in the personal domain. The supervisee's work can be impacted by personal circumstances and challenges, and this may arise as part of the exploration and reflection in CS. In these situations, supervisors may encourage supervisees to seek support and professional care as needed for their health and wellbeing, including via the Nursing and Midwifery Support Service, Employee Assistance Program (EAP) and/or their local doctor.

Choice within the supervision relationship

At the beginning of every supervision relationship, a CS agreement is required. This agreement allows the supervisee and supervisor the opportunity to establish how CS will occur by considering the following:

- choice of supervisor
- choice between individual or group CS.
- expectations and boundaries for the supervision relationship
- supervisor and supervisee availability, including flexible arrangements for time and venue in negotiation with organisational managers
- agreed models and mode of CS
- frequency of review of the CS relationship.

Dual relationships

Dual relationships occur when there are multiple connections within the supervision relationship. These connections can include personal, social, familial and/or professional connections. Dual relationships can create power imbalances and conflicts of interest, particularly when managers provide CS to their own team members. Therefore, dual relationships should be avoided where possible (Australian Clinical Supervision Association (ACSA), 2017).

Managers and organisations can support supervisee and supervisor matching by promoting and directing supervisees to the CS register which can be found on the CS SharePoint site. If dual relationships cannot be avoided, this should be managed by acknowledging any power imbalances and conflicts of interest, and aim to minimise bias, exploitation and lack of objectivity (ACSA, 2017).

Principle 4- CLARITY

The responsibilities of supervisees, supervisors, managers and organisations are clearly understood and supported by organisational policy and guidelines.

Implementation of CS requires strong and consistent organisational support.

ACM, ACMHN, ACN, 2019

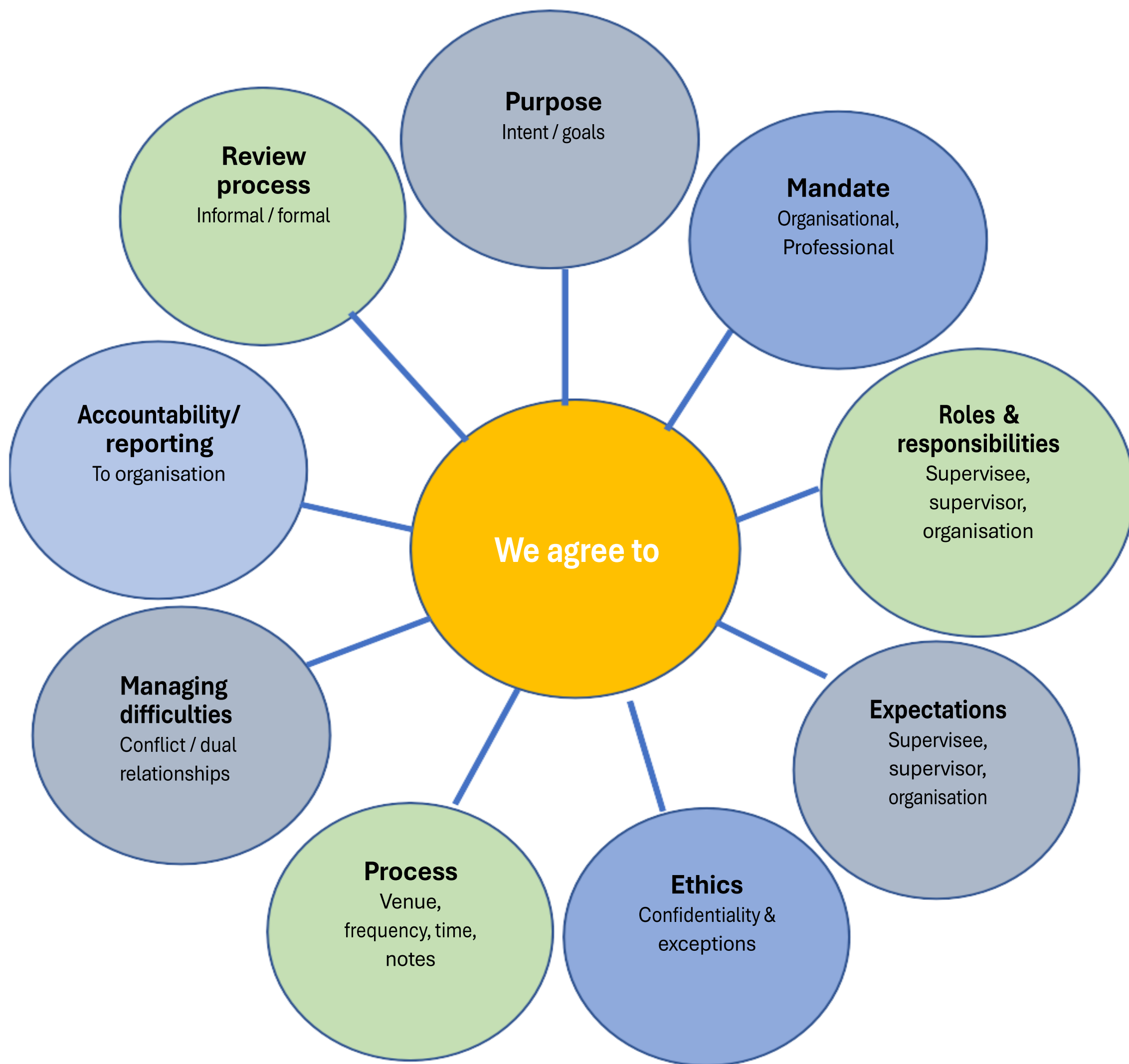
Responsibilities in the clinical supervision relationship

CS implementation and effectiveness is supported by the fulfilment of designated responsibilities by each party, including the supervisee and the supervisor. Supervisees play an active role in CS by contributing to a reflective, respectful and growth orientated partnership. Supervisors require appropriate knowledge and skills to provide CS that enables self-reflection in a safe and supportive environment. Effective supervisors are experienced healthcare professionals who demonstrate the qualities and attributes that reflect professional and organisational values and standards.

Role	Responsibility
Supervisee	• understand CS principles and practice • negotiate access to regular CS with managers, including their choice of supervisor to meet learning needs, limit dual relationships, and/or seek specialist knowledge • contribute to governance and documentation according to organisational CS policies and guidelines, including supervision agreements (see Appendix 1) and record keeping obligations, to ensure consistency and accountability • maintain professional boundaries by respecting the ethical and professional boundaries that underpin safe and effective supervisory relationships • prepare for meaningful engagement by attending supervision with relevant topics, experiences and/or challenges to explore, fostering purposeful reflection and dialogue • be open to new learning to gain deeper insights about work, and to increase self-awareness • prioritise protecting time for CS as a core component of professional practice by safeguarding scheduled time and minimising disruptions • seek additional learning or support identified in CS to develop professional knowledge, skills and personal wellbeing • take active steps to apply learning from CS and ongoing critical reflection into professional practice • store CS documentation in a secure place • contribute to the evaluation and feedback of CS according to organisational policies and guidelines.

Role	Responsibility
Supervisor	• demonstrate professional competence through initial and ongoing CS training programs to ensure knowledge and skill development is consistent with best practice • acknowledge existing cultural biases, assumptions, stereotypes and prejudices and how these can impact the supervision relationship • participate in ongoing cultural safety, diversity and inclusion training to ensure the delivery of culturally safe and responsive CS • in collaboration with the supervisee, lead the development of a CS working agreement for each supervision relationship (see Appendix 1) • facilitate reflective practice through a structured and collaborative approach that encourages supervisee led reflection • uphold professional standards of CS, including confidentiality and ethical and professional boundaries • coordinate logistics of CS sessions, including room bookings and communication relating to scheduled supervision sessions • collaborate with management to ensure adequate time and resources are allocated to supervision responsibilities • commit to CS by prioritising regular CS sessions and maintain continuity and reliability in supervision relationships • provide CS within the scope of their expertise - supervisors who use a model based on psychoanalytical or other models based on therapy first require expertise in these models • participate in CS activities across the organisation, including the CS community of practice and annual CS forum • contribute to data collection, evaluation and feedback of CS according to organisational policies and guidelines, while maintaining confidentiality of CS content • participate in supervision as a supervisee to support professional growth, reflective practice and role modelling • seek opportunities for positive self-care, including taking breaks, and maintaining a reasonable balance with CS provision and workload (Appendix 2).

Figure 2: Elements of the CS agreement (Te Pou, 2017)



> **It is recommended that all employers of nurses and midwives positively support and actively promote quality clinical supervision through organisational policies, procedures, and workplace culture.**
>
> **ACM, ACMHN, ACN, 2019**

Organisation responsibilities in clinical supervision

Strong organisational commitment to CS is essential for the effective implementation of CS for nurses and midwives. Clear organisational responsibilities must align closely with the responsibilities of supervisees, supervisors and managers to create a cohesive, effective and sustainable CS culture.

Role	Responsibility

Manager	• understand CS principles and practice (Appendix 3)
	• support CS access for nurses and midwives:
	  ○ direct staff to the: CS framework, organisation-specific CS policy and guidelines, CS Coordinator, CS intranet and/or database site
	  ○ assess and address the team's readiness for CS (Appendix 4)
	  ○ roster to enable education about CS, training of supervisors, and regular time away from the immediate work environment for CS sessions
	  ○ support for supervisors to provide CS whilst balancing other workload responsibilities, professional goals, availability and self- care
	  ○ support concerns regarding the implementation of CS raised by supervisees and/or supervisors.
	• monitor and support ongoing development of supervisory skills within the team
	• contribute to and store CS documentation in a secure place

Role	**Responsibility**
Organisation	• provide CS education, training and CS resources to enable a consistent understanding of CS across the organisation • provide a structured training model for supervisor training, including refresher training and advanced practice skills, as well as • provide a CS Aboriginal and Torres Strait Islander Clinical Supervision Mentorship Program • incorporate CS education into orientation and induction processes • have a strong commitment to the access to CS for all nurses and midwives at all organisational levels (executive managers to service delivery) • ensure clear governance and structures that protect the expertise of Aboriginal and Torres Strait Islander supervisors, without placing

	additional unpaid cultural duties and responsibilities on individuals, and affirming that cultural safety remains an organisational responsibility • set up governance and provide resources to support CS sustainability, and alignment to NSQHS Standards through: ○ clear CS policy and guidelines based on the framework ○ provision of a CS community of practice that provides a space for connection and collaboration ○ commitment to an annual CS forum to allow CS networking, learning and shared best practice • a dedicated CS Coordinator to support CS implementation. This role should include: ○ facilitation of initial and ongoing CS training ○ oversight of adherence to supervisor requirements ○ management of a CS database that supports supervisor matching ○ management of CS resources that assist with the implementation of CS ○ evaluation of the application and impact of CS and implemented training resources ○ primary liaison for escalation of CS matters

Principle 5- LEARNING

Education about CS, and the continuous development of supervisors through experiential learning enables quality CS for supervisees.

Particular skills, knowledge and attributes have been repeatedly associated with effective individual and group clinical supervision, and it is agreed that supervisors require specific training programs in order to practice.

ACM, ACMHN, ACN, 2019

Clinical supervision education

CS education aims to promote a clear and consistent understanding of CS. Education can take various formats including workshops, mixed modes, and/or online equivalent.

Content includes:

- an overview of the position statement on CS for nurses and midwives, the ACT Government CS framework for nurses and midwives, and CS policy and guidelines
- CS definition, purpose, and functions
- how CS is provided, and the process for supervisee and supervisor matching
- commitment to providing cultural safe and inclusive CS, according to the needs of the supervisee
- the CS agreement, including the responsibilities of the supervisee, supervisor, manager and organisation
- modelling of a CS session
- how to access CS resources across the organisation
- evaluation of the supervisee and supervisor relationship and CS sustainability.

Supervisors require specific training programs to practice. Without training, the clinical supervision provided is more likely to be inadequate, counterproductive, or harmful.

ACM, ACMHN, ACN, 2019

Supervisor training

Specific education and training as a supervisor are consistently identified as an essential requirement of CS implementation.

Essential participant selection criteria:

- Minimum of 3 years' post-registration experience
- Demonstrated leadership attributes and commitment to organisational values
- Commitment to initial and ongoing CS learning requirements, including cultural safety, diversity and inclusion training
- Availability to provide and receive CS
- Minimum of 1 year experience as a supervisee.

To support safe and consistent practice, this framework recommends that staff seek clinical supervision training through their organisation first. Where organisational training is not available, staff should seek training that incorporates an experiential learning approach, such as active participation in real or simulated practice supported by reflection and feedback. CS training models should also encompass cultural safety and inclusive language principles that represent the diversity of the workforce.

Aboriginal and Torres Strait Islander Clinical Supervision Mentorship Program

Establishing a dedicated mentorship program will strengthen culturally aligned CS for Aboriginal and Torres Strait Islander nurses and midwives. The program will enable culturally grounded reflective practice, leadership development, and the integration of Aboriginal and Torres Strait Islander ways of knowing, being and doing. A mentorship model aligns with the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan (2022), by increasing representation and support across health disciplines, building skills and leadership capability within the Aboriginal and Torres Strait Islander health workforce, and contributing to culturally safe, responsive, and racism-free workplace environments (Department of Health, 2022).

Principle 6 – QUALITY

Regular review of the supervisee and supervisor relationship, the effectiveness of CS, and implementation monitoring and evaluation, enhances continuous quality improvement.

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

ACM, ACMHN, ACN, 2019

Quality is central to achieving effective CS for ACT nurses and midwives with a focus on supervisee support and development. A continuous quality improvement approach enables informed decision-making, accountability for the use of resources, a responsiveness to any sustainability challenges, and confidence in the efficacy of CS for supervisees. Use of a standardised approach to CS evaluation will assist the comparison of outcomes.

Evaluation methods

Monitoring and evaluation of CS is recommended at the supervisee, supervisor, and organisational levels to ascertain CS outcomes over time.

A range of methods can be used to evaluate CS, including:

- feedback to the supervisor at the conclusion of each CS session by the supervisee - the Leeds Alliance in Supervision Scale (Wainwright, 2010) is a brief 3-item scale that can be used for discussion on the focus, relationship, and usefulness
- review of the CS agreement by the supervisee and supervisor after 3 to 6 months to determine if any modifications are required and to check if CS is meeting the needs of the supervisee (Appendix 1)
- a formal evaluation of CS outcomes by the organisation on an annual basis with participation by supervisees, supervisors, and managers
- collecting qualitative and quantitative data through surveys, semi-structured interviews, and focus groups
- validated tools such as the Manchester CS Scale – 26 item (MCCS-26) (Winstanley & White, 2011), Generic Supervision Assessment Tool (GSAT) (Hamilton et al., 2021), and the CS Evaluation Questionnaire (CSEQ), (Horton et al., 2008) which assess the impact of CS
- continuous monthly reporting of the number of CS sessions provided by supervisors
- participant evaluation of education about CS, and supervisor training.

Implementation of clinical supervision is a continuous process. So too, is the evaluation of the effectiveness of implementation against locally agreed measures to ensure the quality and efficacy of local clinical supervision arrangements are able to be demonstrated and regularly reported.

ACM, ACMHN, ACN, 2019

Other measures and formal research

Other measures used to determine outcomes from engagement in CS have been used and recommended in the literature, including the impact on workforce capacity and health. For example:

- stress and burnout scales
- job satisfaction
- audits of sick leave and stress leave and Work Cover claims
- service-user appreciation and complaints.

Evaluation of CS implementation for nurses and midwives in the ACT also provides an opportunity for formal research to gain a deeper understanding of best practice and the impact of CS on the ACT health workforce. Use of the position statement and framework as the basis of small and large-scale research on CS in the ACT will contribute to the growing body of knowledge nationally and internationally. Partnerships with tertiary education providers to guide investigation of CS would also support development of knowledge and skills in the conduct of research.

Appendix 1 Clinical supervision agreement template

CLINICAL SUPERVISION AGREEMENT	
Supervisee Name	
Supervisee profession	
Supervisee team	
Supervisee manager	
Supervisor name	
Supervisor profession	
Agreement start date	………/………/……….
Agreement review date	………/………/……….
Booking supervision	The Supervisor will arrange a suitable venue and invitations for all scheduled sessions (unless otherwise agreed)
Frequency of supervision	Weekly ☐ Fortnightly ☐ Monthly ☐ Other ☐
Form of supervision	e.g. Face to face / virtually
Acceptable cancellation reasons	(e.g. annual/sick leave etc.)
Notice of cancellation	SMS / voicemail / phone call / e-mail / other
Storage	The supervisee is responsible for the storage of clinical supervision records in line with the Clinical Supervision Guideline for nurses and midwives
Supervisor Name: ______________________ **Signed:** ___________________ **Date:** ______________	
Supervisee Name: _______________________**Signed:** ___________________ **Date:** ______________	
Manager Name: _________________________ **Signed:** _____________________**Date:**__________________	

A copy of the <u>first page</u> of this agreement is to be provided to your line manager as evidence of your supervision arrangements.

Clinical supervision goals of the supervisee:

1. ____
2. ____
3. ____
4. ____

Clinical supervision sessions

The supervisee will prepare for each session by:

____

____

The supervisor will prepare for each session by:

____

____

Should a session need to be rescheduled, we agree to:

____

____

Confidentiality

Confidentiality is a priority. What is said in CS sessions, stays in that space, unless discussions impact the health, wellbeing and/or safety of the supervisee, the supervisor and others. The supervisor and supervisee will discuss how to manage these incidents when they occur. It is an AHPRA requirement that a disclosure of the following incidents will require a mandatory notification:

- impairment
- intoxication while practising
- significant departure from accepted professional standards
- sexual misconduct.

Evaluation

How will evaluations occur?

____

How often will these reviews occur?

____

Supervision review

Has clinical supervision contributed to your professional growth?

____

____

Is the current clinical supervision model meeting your needs and expectations?

____

____

Do you feel our supervision relationship is supporting your growth and goals?

Other considerations

Appendix 2- Creating a self-care plan

To create (or improve) a self-care plan, it is important to begin by understanding what strategies you currently use when you experience a stressful situation.

Everyone has their own strategies to cope with situations, but they may not always be positive for ongoing health and wellbeing. Positive strategies typically promote calm both emotionally and physically, allowing the person to relax (known as self-care).

Negative strategies create the opposite effect increasing stress and agitation which can impede a person's ability to cope with a situation and in some situations make it worse.

Types of strategies

Positive	Negative
Deep breathing	Yelling
Listening to music	Smoking
Exercising	Pacing
Meditation	Skipping meals
Reading	Drinking alcohol to excess
Connecting with others	Withdrawal from family and friends
Engaging in a hobby	Biting fingernails

Reflect. Examine. Replace.

To identify what strategies would work best to help promote calm and facilitate your ability to process stressful situations, consider what you value in your everyday life as well as during difficult times. Focusing on activities that leave you feeling positive will help you to create a self-care plan.

Ask yourself if you are practicing these types of activities or if you have developed some negative practices ?Spending time reflecting on what you want your self-care plan to look like can help you into the future, as you will be addressing your ongoing physical, psychological, emotional, spiritual, social, financial and workplace wellbeing requirements.

Strategy	Action
Reflect	On your existing coping strategies to identify what works and what doesn't
Examine	Barriers that may stop you understanding or maintaining your self-care strategies
Replace	Negative coping strategies with positive strategies. Start small and pick one to address at a time e.g., replace a negative strategy, like drinking too much alcohol with a positive strategy: pick at least one day in a week where you will not drink.

Create a self-care plan

Think about committing your self-care plan to paper and being accountable for what you write down. Share your self-care plan with someone you trust.

Start by identifying your own personal needs and any current strategies you use and then identifying some different practices you might want to consider trying. The self-care plan template is a useful resource for getting started.

Commit to revieing your self-care plan on a regular basis, tweaking it to meet your changing needs and state of wellbeing.

Self-care plan template

When using this template, look at your current self-care strategies and then consider what you might want to maintain or change. Consider taking inspiration from your friends, family and work colleagues, but remember to create a plan that will work for you and address your needs.

Self-care area	Current strategies	Strategies to try
Physical		
Emotional		
Spiritual		
Professional		
Social		
Financial		
Psychological		

Appendix 3- Clinical supervision- Frequently asked questions for manager

Staff have asked for clinical supervision. What is it?

Clinical supervision is a formally structured meeting with a trained clinical supervisor, that facilitates the development of critical reflective practice. It is a professional development activity, to increase awareness and understanding of complex workplace issues, and gain problem solving skills.

Should all health care workers attend clinical supervision?

Clinical supervision is recommended for all healthcare workers as a voluntary professional development activity.

Can I provide clinical supervision to staff?

No. It is important that staff choose their own supervisor. A clinical supervisor should not have organisational responsibility to direct, coordinate or evaluate the performance of the supervisee. You can help staff find a supervisor at Find a supervisor.

One of staff has trained as a clinical supervisor. Can they supervise their colleagues?

No. To avoid power imbalances and conflicts of interest, a clinical supervisor should not provide clinical supervision in their clinical area.

How do I find a clinical supervisor for staff?

Please head to Find a supervisor which is located on the Clinical Supervision SharePoint site to find a register of ACT Government clinical supervisors.

A staff member would like an external clinical supervisor—do I need to pay for this?

No. Staff may choose to access an external clinical supervisor, and this would generally be funded in the same manner as other professional development entitlements.

Will staff have to travel to attend clinical supervision?

Clinical supervision can be conducted face to face or virtually. Some clinical supervisors also have the capacity to travel. Please check in with individual supervisors.

Does clinical supervision have to be conducted in work time?

Clinical supervision is a professional development activity and, therefore, should be conducted in work time.

A staff member has been receiving clinical supervision for some time and their practice issues are not improving. Can I ask their clinical supervisor for updates on their progress?

No. The content of clinical supervision is confidential (unless it breaches ethical or legal boundaries of professional practice). Clinical supervisors cannot discuss issues raised in the sessions and should not be asked to do so.

We had a busy shift and were unable to replace sick leave. A staff member had clinical supervision pre-arranged and left the ward anyway. Is this okay?

Clinical supervision session times need to be negotiated with managers in advance. If there's an unforeseen increase in clinical workload, then all steps should be taken to support the staff member's attendance at clinical supervision. If this is not possible, then the clinical supervision session may need to be rescheduled.

Adapted from QLD Health

Appendix 4- Clinical supervision readiness checklist

This readiness checklist will indicate how ready your team/organisation are to proceed with implementing clinical supervision in your workplace.

Please answer Y or N in each row	Y or N
Executive support Do you have a leader who has decision making capabilities within the organisation **AND** knowledge of, and commitment to clinical supervision?	
Executive leadership Do you have a leader who understands the principles of clinical supervision and the inherent difference between clinical supervision and other professional development support systems such as point of care supervision and facilitated professional development?	
Team knowledge Does your team understand the principles of clinical supervision and the inherent difference between clinical supervision and other professional development support systems such as point of care supervision and facilitated professional development?	
Culture Team culture identifies strengths in staff support and communication. There is transparency, collaboration and a commitment to learning.	
Resources Time has been provided for the team to engage in clinical supervision. Rooms are available to support clinical supervision.	

More than 2 ‘No’ responses may indicate your team is not ready to implement clinical supervision. Please contact the clinical supervision for further support and resources.

Adapted from QLD Health

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