NFP Reflective Supervision: Project Report

NFP International team
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2019.04.24

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Nurse-Family Partnership
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INTRODUCTION

This report summarises the findings of the International NFP reflective supervision project undertaken by the NFP International team between Sept 2018 and March 2019. The report is intended for the NFP leads in each country and identifies proposals for a new NFP reflective supervision framework alongside recommended next steps to be taken to ensure that learning from this project is taken forward. The International team would like to take this opportunity to thank all the Clinical Leads, NFP supervisors and nurses and Policy makers who contributed their experiences and expertise to this project. It was a truly collaborative international piece of work.

Context for Project

The expectations for use of reflective supervision (RS) within NFP are embodied within the International Core Model Element # 12, which states:

> *Each NFP team has an assigned NFP Supervisor who leads and manages the team and provides nurses with regular reflective supervision*

Currently, NFP implementing countries are utilizing a variety of different supervision models and approaches to support and enhance NFP nursing practice. Clinical Leads (CLs) expressed an interest in sharing the learning that has arisen from these varied approaches and exploring the potential for the development of a best practice Reflective Supervision model for NFP within this project. For this project the International team focused only on 1:1 Reflective Supervision including field supervision/ observed home visits (OHVs). Any group activities such as case conferences, team meetings, and education/learning activities were out-of-scope.

Project Goal

To develop a guidance document and Reflective Supervision Framework/model for NFP that: outlines the purpose, core standards, principles, and expectations; identifies recommended practice approaches; and provides resources to support successful implementation and evaluation.

- This report has been developed based on an analysis of information provided by each country, professional/policy contexts, the research literature, and the NFP program model.
- The Guidance Document to be developed alongside this report will be disseminated to the Clinical Leads with the expectation that it will guide the implementation and assessment of reflective supervision in their country, thus providing an opportunity for quality improvements.

METHODS

A combination of methods were used within the project:

- In order to ensure that any recommendations regarding reflective supervision in NFP were grounded in evidence and best practice:
    - A high-level literature review was conducted, related to reflective supervision.

- In order to determine and assess the approach to reflective supervision currently being used within each NFP country:
  - The NFP international consultants conducted individual interviews with each county's designated Clinical Lead(s) and any other requested key informants using the tool found in Appendix C.
  - Each country provided a written summary response to two questionnaires developed for the project for NFP nurses and supervisors (refer to interview tools found in Appendix D and E). It was agreed that the Clinical Leads would determine how many NFP nurses/Supervisors would complete the questionnaires, how the data would be collected, and how it would be summarized. Clinical Leads were encouraged to seek input from as many staff as possible.
- In order to understand the professional context for reflective supervision in each country:
  - Clinical Leads provided professional and policy documents/web links which address the use of reflective and clinical supervision within their country. These were reviewed to assess the impact of context on the development of an International model. The policy documents provided were high level and broadly supportive and encouraging of supervision within nursing, without any evident challenges for the NFP model.
- In order to understand opportunities and challenges associated with data collection for this CME and documentation to support and report on reflective supervision:
  - Clinical Leads from all English-speaking countries provided copies of the documentation and data collection tools they use for reflective supervision

Clinical Leads have provided feedback on the approach used, interview guides/questionnaires, draft project report, and draft guidance document. Wherever possible this feedback was incorporated into the final project documents.

BACKGROUND

The Use of Reflective Supervision in NFP

When the NFP was first developed, and evaluated in the Elmira trial, formal reflection on one's work was not an established practice of nursing professionals. Like many other home visiting nurses, NFP nurses work alone with clients in often difficult environments, in contrast to hospital nurses, who may have the support of on-site peers and supervisors. The Elmira, New York nursing team identified a need for structured support to sustain them in this work that was isolating and often emotionally draining.[1] As a result, reflective practice and supervision were built into the program with Dr. Olds leading weekly case conferences.

> "I saw my primary role as really helping them [the nurses] think through the cases that were problematic in light of the underlying theoretical model of the program…. One of the things we would talk about a lot is the nurses' feelings of frustration and inadequacy in their ability to really bring about the kind of changes they all envisioned and were committed to seeing occur." (D. Olds, personal communication with the US NFP National Service Office, December 19, 2006).

By addressing their feelings in a safe and supportive environment, nurses were able to be more therapeutic in their interactions with clients. In addition to the weekly case conferences, the supervisors supported the nurses' practice through reflective supervision. Supervisors made joint home visits with the nurses and team members made joint visits with each other, to "provide another pair of eyes and ears and to provide support to one another" (D. Olds, personal communication, December 19, 2006). Similar approaches were followed in the Memphis and Denver trials.

Reflective supervision has been an important part of NFP nursing practice since the three US randomized controlled trials. However, in the early replication sites, NFP supervisors were not consistently conducting weekly one-to-one reflective supervision or timely case consultation sessions. In their orientation of new agencies, the US National Service Office (NSO) began to strengthen orientation to the model for site decision-makers so that they understood what made the frequency and nature of supervision in NFP different from the more typical administrative supervisory responsibilities to which they were accustomed. The NSO also added specificity to recruitment guidance for the role of NFP nurse supervisor and intensified training on reflective supervision for new supervisors.[2] The principles of regularity, collaboration, mutual respect, and open communication were integrated into the NFP program through one-to-one reflective supervision, case conferences, and observed home visits with the supervisor. [3]

Reflective supervision in NFP guides the NFP nurse, in collaboration with her supervisor, to deeply reflect on specific events she experiences in her NFP work. Using the model/framework, the NFP nurse attends to her positive and negative feelings about the event and evaluates the experience in order to understand and plan how she would act in a similar situation in the future. [4]

NFP uses a solution-focused approach to support the achievement of self-efficacy and Motivational Interviewing (MI) approaches to support anticipatory preparation and behavior change. A basic assumption of this approach is that clients are experts about their own lives (one of the NFP client-centered principles) and can work collaboratively with health professionals to co-create solutions to challenges confronting them. To support the NFP nurses, opportunities are provided weekly during team case conferences to discuss application of these approaches and techniques to specific families. Additionally, individual reflective supervision is utilized to role model the principles of solution-focused interactions (parallel process) and use of MI. It is important that the techniques be thoughtfully applied as opposed to becoming a routinized formula superficially used in every situation.[5] In the supportive environment of a reflective supervisor who listens, waits and productively guides the discussion, the NFP nurse can make sense of their own emotional response, explore concepts, develop new understanding and discover solutions.

Reflective Supervision in NFP ensures the NFP nurse has time and support to: consider her own responses to the work; link those responses back to previous experience; consider how those responses may guide future action; wonder about what is happening for the parents and baby/child; and consider a variety of possible links between all of these factors.[6] [7] [8] The possibility of significant harm coming to a baby or a child within their caseload as a result of child abuse is an ever-present fear for NFP nurses. Because of this, the UK NFP countries have specifically imbedded a "safeguarding" component into their reflective supervision. Safeguarding supervision is an important element in helping to mitigate the effects of vicarious trauma and compassion fatigue.[9]

NFP international has encouraged countries to utilize a reflective supervision model of their own choosing (as these models are not intended to be prescriptive in their application), but instead embraced as a framework for practice. [10] NFP supervision includes reflecting on the application of the methods, approaches and materials of the program and is crucial to prevent misuse of the approaches. NFP reflective supervision asks nurses to address the 'why' and 'how' of their practice, supporting them to move from current understanding and knowledge to a more uncertain place where they question their assumptions, understanding, and beliefs.[11] The NFP supervisor can then highlight the nurse's growing skillset and knowledge base of the approaches, their efficacy, confidence, and increasing skills and experience of working with the mother and her infant.[12]

Reviewing reports generated by the country's NFP information system based on nursing assessment data gathered on every home visit, as part of the reflective supervision process enables the supervisor to recognize and address implementation successes and challenges with their nurses.[13] Analyzing and reviewing program data during reflective supervision: supports reflection on practice for maintenance of program fidelity and prevention of program "drift"; identifies improvements required in clinical practice; and identifies areas of strength and areas requiring attention.

NFP teams that are well-led create a culture of excellence and mutual growth, by developing a reflective and open approach to the analysis of the teams' work. In addition to reflection, regularity and collaboration are essential features of reflective practice.[14] Regularity refers to scheduled, uninterrupted

time for a supervisor to meet individually with each nurse and for the team to meet together. Developing an environment of acceptance, trust and support requires time and a commitment to protect that time. A commitment to be prepared and open for learning through reflection is also essential and is a core attribute to seek when recruiting nurses.

Home visit observations are used to evaluate the content and quality of activities that occur during the home visit, the quality of the nurse-client relationship, and the level of family engagement in the program. This focus on assessment and feedback on the quality of service provided can help inform home visiting practice, guide overall program improvement, and inform continuous quality improvement efforts.[15]

PROJECT FINDINGS

The findings from the literature review, Clinical Lead interviews and surveys of NFP supervisors and nurses conducted within the project are set out below:

A. LITERATURE REVIEW

The literature review reconfirmed a distinction between reflective practice and reflective supervision.

Reflective Practice

The emphasis on reflection in nursing education and practice emerged from the seminal work done by Donald Schon who believed that effective professionals engage, intuitively, in a reflective conversation with their problems/issues, probing them, reframing them, and relating them to previous situations. He developed the concepts of reflection-on-action and reflection-in-action, which explain how professionals meet the challenges of their work with a kind of improvisation that is improved through practice.[16] Johns believed that reflecting on one's experience enables the practitioner to assess his or her own behavior to expose the contradictions between the ways he or she practices and what he or she aims to achieve.[17] Tanner built upon this, stating that reflection is critical for the improvement of clinical reasoning and the development of clinical knowledge.[18] Reflection is therefore a process for learning, professional growth, and change.

"Reflection is an important human activity in which people recapture their experience, think about it, mull it over and evaluate it. It is this working with experience that is important in learning." *Boud D, Keough R, Walker D. (1985). Reflection: Turning Experience into Learning. London: Kogan Page; p. 43*

"It is not sufficient simply to have an experience in order to learn. Without reflecting upon this experience, it may quickly be forgotten, or its learning potential lost. It is from the feelings and thoughts emerging from this reflection that generalizations or concepts can be generated. And it is generalizations that allow new situations to be tackled effectively." *Gibbs G. (1988). Learning by Doing: A guide to teaching and learning methods. Further Education Unit. Oxford Polytechnic: Oxford; p. 9*

"We learn through critical reflection by putting ourselves into the experience & exploring personal & theoretical knowledge to understand it & view it in different ways." *Tate S, Sills M. (Eds.) (2004). The Development of Critical Reflection in the Health Professions. London; Higher Education Authority; p.126*

Reflection is an exploration of the "content, process and premise underlying the experience in an attempt to make meaning or better understand the experience." This in turn will lead to changes in your "behavior that reflect changes in underlying values, attitudes, and beliefs." Plack M, Greenberg L. The Reflective Practitioner: Reaching for Excellence in Practice. Pediatrics. 2006;116(6):1546-52; p.1547

Reflective practice can be used to help nurses to make sense of work situations and, ultimately, to improve care and has therefore become an essential component/standard of professional practice for

nurses and other health professionals. [19] [20] [21] Reflection is a powerful tool to enable learning from our experiences in that it helps health professionals to:

- Understand what they already know (individual)
- Identify what they need to know in order to advance understanding of the subject (contextual)
- Make sense of new information and feedback in the context of their own experience (relational)
- Guide choices for further learning (developmental)

http://pcwww.liv.ac.uk/ehls/prescott/Practice-Education/_20.htm

Reflective practitioners "…are more confident about their own values and how to put them into practice; they integrate knowledge, values and skills; reflect on practice and learn from it; are prepared to take risks and moral blame." (Banks, 2006, p. 140).[22] Interpersonal skills, self-awareness, and the ability to influence others towards positive change are key skills for NFP nurses. Reflective practice facilitates the development of these skills by fostering an understanding of practice events and how one's own approach, personality and personal history contributed to the way situations arose and how they were dealt with.[23] [24] Reflective capacity is defined as "…being aware of one's own personal thoughts, feelings, beliefs, and attitudes as well as understanding how these practices affect one's behaviors and responses when interacting with others." (Tomlin et al., 2014, p. 71) [25]

➢ Refer to APPENDIX A: *Reflection and Supervision Models/Frameworks for a brief description of the reflective supervision models, most commonly used in NFP*.

Reflective Supervision

Reflective supervision is a "specialized approach to supervision that engages both supervisors and supervisee in exploration and inquiry extending beyond the facts to include the experiential nature of the relationship with the infant or toddler and family." Shea SE, Goldberg S. Training in reflective supervision: building relationships between supervisors and infant mental health specialists. Zero to Three J. 2016;37(2):54-62; p. 55

"Reflective practice and clinical supervision are seen as approaches to enable nurses, midwives, and allied health professionals to reflect on aspects or events within their practice; to examine what happened, what was good or bad about the experience, what else could have been done and what could be changed or improved in practice as a result of this learning." NHS Education for Scotland (2017). Clinical supervision for midwives. Unit 1; Fundamentals of clinical supervision. https://www.nes.scot.nhs.uk/media/3963029/CSM%20Unit%201.pdf

"Reflective practice is about getting into the habit of consciously and deliberately examining situations, actions and responses, and changing your practice as a result. Clinical supervision can provide a supportive and safe framework for reflection, helping nurses develop their professional skills." *McDonald J, Glover D. Reflective Supervision. Nurs Times. 2000;96(12):49-52; p.49*

Reflective supervision is distinct from other types of supervision as it utilizes a reflective cycle to explore the individual's unique experiences, allowing him/her to discover solutions, concepts and perceptions on their own without direction from the supervisor. [26] It is different to traditional clinical supervision which is often instructional, directive and prescriptive where the supervisee can feel more of a passive participant. [27] Clinical supervision is case-focused but does not necessarily consider what the practitioner brings to the intervention, nor does it necessarily encourage the exploration of emotion as it relates to work with clients.[28] Reflective supervision is characterized by three key components: reflection, collaboration, and regularity/consistency of the relationship.[29] Regularity refers to scheduled, uninterrupted time for a supervisor to meet individually with each supervisee and for the team to meet together on a regularly scheduled basis.[30]

Reflective supervision is a collaborative relationship between supervisor and supervisee that is constantly evolving and maturing, embracing new knowledge and skills.[31] Effective reflective supervision requires regular, protected time for facilitated, in-depth reflection on clinical practice.[32] It brings practitioners and skilled supervisors together to engage in a formal process of professional support and learning.[33] The success and effectiveness of the supervisor-supervisee relationship is contingent upon mutual commitment and collaboration.[34] [35] [36] [37] Reflective supervision is designed to support and enhance the supervisee's reflective practice skills.[38] [39]

Participating in reflective supervision is not simply about acknowledging what the individual's skills are now, what went well and what went wrong; it is also about who they might become as a professional – it can be a transformational process.[40] "In transformational learning, supervisees critically reflect not just on their experience but the way they construct their experience." (Carroll, 2010, p. 16) [41]

An effective supervisory relationship mirrors a positive therapeutic relationship/alliance in which emotional safety is created to facilitate the exploration of difficult feelings, progress towards achieving goals, and assessing the growth in the parent–infant dyad relationship. [42] This process, sometimes referred to as "containment" or "emotional regulation", supports and fortifies the supervisee professional to continue working with their complex families even when progress is slow or appears stalled. [43] [44] The supervisor-supervisee relationship should utilize a parallel process which can raise awareness and insights to inform what is happening in the client system.[45] It also should utilize approaches such as observation, modelling and feedback.[46]

An analysis of the Oregon Healthy Start program using hierarchical general linear modeling examined the community, home visitor, and maternal attributes that predicted retention in the program beyond one year. The only attribute significantly associated with program retention was the average number of hours of supervision that the home visitor received each month. The authors conclude that "supervision is essential, as families with multiple risks often require services beyond the home visitor's expertise." (McGuigan et al. 2003, page 374) [47]

For nurses providing home visits, the complexity of the work, and working in isolation from their

colleagues can be stressful and emotionally draining. They are not able to easily access the professional support networks available in other forms of nursing practice which are known to be key protective factors in preventing burnout and compassion fatigue. “Restorative supervision” is an evidence-based model that has been designed to support the needs of professionals working with clinically complex caseloads and/or in roles which demand they be clear thinking and able to process information quickly and accurately in order to make decisions. The focus of the model is to enhance the resilience of the professional, improving their own health and well-being, preventing burnout/compassion fatigue, and supporting their capacity to make complex clinical decisions. [48 49 50 51 52]

Reported Outcomes of Restorative Supervision:

- Accessing support
- Better relationships amongst staff
- Catharsis
- Coping
- Empathy
- Engagement in the workplace
- Improved coping at work
- Improved relationships with colleagues
- Increased interest relief
- Listening and being supportive
- Lower received anxiety
- Personal accomplishment
- Personal development
- Reduced burnout
- Reduced conflict
- Reduced tedium
- Relief of thoughts and feelings
- Safe group environment
- Satisfaction
- Self-understanding
- Sense of community
- Sense of security
- Trust
- Understanding colleagues

Adapted from: *Brunero S, Stein-Parbury J. The effectiveness of clinical supervision in nursing: an evidenced based literature review. Aust J Advan Nurs. 2008;25(3):86-94.*

The trusting relationship between the supervisor and supervisee provides a respectful and thoughtful space where observations, authentic feelings, thoughts, and ideas can be explored on a regular basis. [53] Participating in reflective supervision creates opportunities for self-exploration and insight. [54] This can positively impact on the quality of service provided, resulting in better outcomes for families. [55]

Effective and highly competent supervisors: [56]

- Work toward developing a strong supervisory alliance by mutually agreeing with the supervisee on the goals and tasks of supervision
- Use effective communication skills such as active listening, reflection of feelings, and empathy to facilitate the development of an emotional bond with the supervisee
- Attend specifically to the evaluation aspect of supervision by facilitating the setting of supervisory goals and providing both formative and summative feedback

Supervisees describe the”…optimal reflective supervisor as one who is attentive, self-aware/self-reflective, able to observe skillfully, curious and engaged, compassionate, tolerant, and nonjudgmental.”

(Tomlin et al., 2014, p. 76) [57] The individual aspects of the supervisor most valued by staff are: clinical expertise, ability to provide new and relevant practice knowledge, and the ability to promote learning in a respectful and safe way.[58] When done well, reflective supervision increases self-efficacy and coping skills of infant mental health professionals.[59] [60] It is hypothesized this will result in in better outcomes for the children and families they serve.[61]

A supervisee's positive relationship with her supervisor has a positive impact on clinical practice and interactions with clients.[62] Supporting the social and emotional needs of staff entails listening to them attentively and empathetically, particularly when they feel overwhelmed, stressed or confused about their work. [63] [64] Job satisfaction and intention-to-stay are directly correlated with the supervisor being socially and emotionally supportive to supervisees. [65] [66] Supervisor-supervisee relationships that are characterized by accessibility, empathy, and praise, also have a positive impact on staff retention.[67] There are five attributes that are consistently noted to support the development of an effective and trusting reflective supervisory relationship: safe, consistent, dependable, respect/confidentiality, and honest.

- Refer to Appendix B: *Attributes That Support the Development of a Reflective Supervisory Relationship*.

B. SUMMARY OF FINDINGS FROM THE INDIVIDUAL INTERVIEWS WITH NFP CLINICAL LEADS AND EDUCATORS

This summary of the perspective and experiences related to reflective supervision has been prepared from information provided during structured telephone interviews with Clinical Leads (CLs) and National Unit NFP educators using a tool developed specifically for this project (refer to Appendix C). Thirteen interviews (with a total of fifteen participants) were conducted by International Consultants in October-November 2018. Eight themes emerged from the participants.

Thematic Analysis

A short summary of the issues related to each theme are presented below, recommendations from the CLs are provided, and brief quotes are included where relevant to illuminate the text.

1. Reflective supervision model

Reflective practice model:

Participants all named a model of reflection that was being used, with Canada, Australia and USA referring to the Gibbs model and UK countries, Norway and Bulgaria citing the Kolb cycle. These two models are quite similar and provide a guiding framework for reflection on events encountered. A

number of participants referred to their use in team meetings and case conferences as well as one-to-one supervision.

Supervision model:

In addition, a number of countries cited using Hawkins and Shohet's Seven-eyed Model (88) to provide a framework for the areas of exploration to be considered as part of the supervisory process.

Approach/method of supervision:

Almost all respondents highlighted the importance of the approach to be taken to reflective supervision as key to the model being used. This was variously identified as:

- Active listening
- Appreciative (not a deficit model)
- Being fully present
- Collaborative (supported by the "How's it going between us?" document)
- Respectful (of nurse, client and supervisor)
- Role modelling, using program methods (e.g. motivational interviewing)
- Supervisor as guiding the process
- Trauma informed
- Trusting and safe relationship

Functions of supervision:

In addition, a number of leads described the functions of supervision. In England these were named as Kadushin's three functions (see Appendix A); supportive/restorative, managerial/administrative and educative and all were seen as important components of 1:1 reflective supervision. Scotland cited Proctor's work (see Appendix A) in relation to these same functions (normative, formative and restorative) and also identified them all as core components of reflective supervision.

Leads in Canada and Australia described a separation of these functions, with 1:1 reflective supervision mostly focussing on the restorative component and other supervisory tasks sometimes being undertaken separately, with the possibility of being less reflective and more directive in style (this was especially the case in relation to the managerial/ administrative functions).

Safeguarding/child protection:

Safeguarding supervision was cited as having an important place in the reflective supervision model by a number of informants. Within this area, focusing on client and child safety was seen as a core function and integral component of the reflective supervision model. In UK countries this is also supported by an additional 'Tripartite' supervision, where a child protection expert meets with the nurse and supervisor every three months or when requested to *"…bring in another perspective [child protection lens] to support the SV and FN to assess, analyze, and articulate where the program is at for the children"*

Comparison to other models of supervision in use within countries:

Although reflective practice was part of initial nurse education in many countries, many CLs reported that its incorporation into a supervision model was relatively rare outside NFP. The NFP reflective supervision model was described by many as much more developed than in other branches of nursing in their country. Others reported that the reflective approach was notably different from models currently in use in other areas of nursing, which were often 'expert' models in which the supervisor was expected to 'instruct' supervisees on case management or more closely aligned to performance appraisal. A number of leads felt NFP reflective supervision was an exemplar that other branches of nursing in their country could learn from and some have developed educational packages for others drawing on their learning from NFP. In one country this was thought to be the first time that supervision for nurses had been introduced in any way.

2. Goals of supervision

Reflective supervision was seen as a vital component of the NFP model by all participants. The goals of reflective supervision were variously described under three main headings: nurse impact, client impact, and quality.

Nurse impact:

- Building resilience of nurses – helping them to feel safe in their role and preventing vicarious trauma
- Enabling nurses to look critically, learn, identify meaning, find solutions to their challenges and change behaviour
- Enabling nurses to critically review their performance and delivery of the program for its intended purpose
- Creating a safe space to explore emotional distress experienced from job – providing containment
- Focusing on nurse self-care/ restorative so that nurses feel valued, heard and understood (so impacting positively on nurse retention)
- Enabling honing of professional practice and maintenance of professional boundaries
- Understanding individual nurse learning needs and goals
- Building nurse confidence as well as developing understanding and competence
- Supporting an appropriate work/life balance

Client impact:

- Enabling nurses to better understand their clients and their work
- Modelling the programme approach, parallel process.
- Providing clients with expert critical thinking of more than one practitioner
- Reviewing individual client progress and planning approaches /plans/priorities for future work
- Supporting safe practice

Quality:

- Assessing team dynamics and how nurses interact with others in her team/organization
- Identifying patterns and trends in nurse or client progress, through reflection on fidelity data/client outcome reports and by noting patterns of nurse behaviours
- Providing security for local Advisory Boards and employers (nurse's competence is assessed and developed)
- Recognising when a nurse is not a good 'fit' for the role
- Supporting quality improvements in program delivery
- Supporting the delivery of high-quality care to clients and children to achieve the programme goals
- Supporting the nurse in managing very complex work and enabling her to access others around her

One CL summarised the goal of reflective supervision in this way:

- *"Focusing on emotional support for the nurse, learning and achievement of program goals for the client and child."*

3. Content of reflective supervision

Almost all informants identified a process of negotiation by both nurse and supervisor to agree the content and priorities for reflective supervision sessions. Most CLs emphasised the importance of prioritising the nurse's needs for reflection, with nothing being 'out of scope'. The supervisor was expected to play an active part in creating a shared agenda, especially in terms of the integration of learning and use of the program model in practice. Many emphasised that preparation for supervision by both nurse and supervisor improved focus and productive time of the supervisory space. The structure of the session was also felt to be important, with the supervisor taking responsibility for this and some countries expect supervisors and nurses to agree a 'supervision agreement' at the outset to agree working practices and expectations of each other.

- *"It's primarily an agenda-matching process, driven by the needs of the NFP nurse."*

There was an expectation that reflecting on cases would predominate the agenda, with most Leads identifying that all cases should be reviewed in reflective supervision over time. However, a number of Leads emphasised the need to focus on nurse working practices (i.e. which assessments, program materials, and clinical approaches had been used) in relation to work with clients, so that impact could be reflected on and analysed to support learning and planning for next steps. There was also an acknowledgement that the challenging nature of the work, with the nurse needing to use empathy and witness some very challenging issues, meant that creating a safe space for exploration of the impact on the nurse was also very important to include in reflective supervision.

Some informants also noted the need to review fidelity data/client outcome reports in the reflective supervision session, so that trends, patterns and progress could be reflected on, although some leads considered this to be better addressed within a different, administrative meeting. Likewise, some leads discussed the need to explore safeguarding or child protection issues within reflective supervision, with supervisors taking responsibility to ensure that a focus on child safety is maintained.

4. Roles and accountabilities

Many leads identified different roles and responsibilities for the nurse and supervisor in the implementation of reflective supervision. Many emphasised the need for the nurse to be acknowledged as having expertise and agency (the authority and capacity to act), with efforts directed at the nurse finding her own solutions to the challenges she faces. Nevertheless, a number of separate, and joint accountabilities were identified.

- *"The Nurse supervisor needs to be clever and brave – they have to explore the potential of all possible scenarios in supervision of clients, opening up possibilities that nurse may not have considered (or wish to see). "*

Roles and accountabilities within a reflective supervision session were described as:

Supervisor:

- To provide structure and use a 'guiding style' towards productive outcomes of the session
- To listen well, observe, make connections and raise issues for consideration.
- To 'wonder' aloud about alternative explanations for occurrences
- To focus on strengths; but also to recognise, and work on, individual nurse limitations/vulnerabilities
- To keep track of cases discussed
- To complete supervision fidelity data forms (and sometimes documentation of session)

Nurse:

- To be open to alternative views and new ways of seeing issues/ cases
- To carry through on plans developed and agreed as a result of reflective supervision

Both:

- To be prepared and make time available
- To contribute to the agenda
- To create a safe space through mutual respect, collaboration, and openness to the process
- To use the reflective practice model

One participant, working in a situation where the managerial and supervisory aspects of the NFP supervisor were undertaken by different individuals, described the accountabilities of all players as a bit

of a 'grey area', where there was the potential for responsibilities for nurse performance falling between these roles and therefore not being attended to.

Impact of reflective supervision

Most informants identified reflective supervision as being central to the achievement of the program outcomes.

- *"Supervision is one of the most fundamental parts of FNP - it improves the quality"*

Specific outcomes were noted as:

- Decreasing sick time/illness, increasing job satisfaction and nurse retention
- Expanding nurse understanding, skills, professional and personal growth
- Focusing on child's experiences - highlights when child protection is an issue.
- Identifying challenges that nurses are experiencing within community served – trends and patterns (e.g. IPV, housing)
- Impacting positively on how nurse works with a client through use of the parallel process
- Improving client retention; as more resilient, skilful nurses will engage clients more effectively
- Increasing nurse objectivity, by critical reflection and challenge to assumptions
- Preventing situations reaching a crisis – for nurses and clients – by reviewing, reflecting, critically analysing and anticipatory planning.
- Supporting a focus on short and long-term goals for client and program outcomes
- Supporting nurses in becoming/remaining resilient, improving coping strategies, reducing stress, burnout and compassion fatigue
- Supporting nurses in managing difficult cases
- Supporting program fidelity/ prevents program drift because the NFP nurse and NS can pick up on variances in practices.
- Supporting team equilibrium through discussion of pressures and stresses.

- *"Nurses are more confident and competent as a result of supervision and therefore the quality of their work (and program) is improved"*
- *"A nurse who feels valued and has a safe base, they are able to think and learn and move forward"*

5. Education and support for NFP supervisors

Supervisor education:

CLs in many countries had paid considerable attention to the educational program for supervisors, which often comprised eLearning, reading, and face-to-face training events. This was reported as having the primary goals of:

- Completing of a 'supervisor self-assessment' and review of personal supervision history

- Enabling supervisors to develop a structured and safe environment for reflective supervision and support critical reflection and analysis by the nurse
- Enabling understanding of the reflective practice and supervision model in use and development of the skills required to support its use within supervision
- Ensuring that SVs understand the CME and fidelity expectations for reflective supervision, as well as its expected impacts
- Supporting 'unlearning' of previous practices and approaches that are not consistent with NFP reflective supervision

The education was often followed up with a series of other supporting strategies, such as:

- Encouraging supervisors to develop self-awareness and work on their own development
- Providing individual mentoring/coaching by a more experienced NFP supervisor or nurse consultant
- Supporting community of practice conference videos/calls or face-to-face events to share practices and challenges and provide peer support

In addition, some CLs reported that sites were required to report on supervision fidelity on a regular basis and all countries were also including reflective supervision as a core component of their NFP nurse and supervisor education. The content and duration of these segments of the core education was not covered in the scope of these interviews.

Reflective supervision for supervisors:

Providing reflective supervision for NFP supervisors was a challenge for many CLs, although most saw it as very important. Some countries had introduced peer reflective supervision arrangements, although one informant felt this was of limited value. The outcome of a peer supervisor arrangement was said to be improved when expectations were made clear and observations of supervision were a core part of the process.

Outside managers unfamiliar with NFP were providing reflective supervision in some countries, but again this was felt to be less than ideal as they were unfamiliar with the program or reflective supervision model. Some CLs stated that they had separated managerial supervision for the NFP supervisor (provided by the local manager) and reflective supervision (with a linked psychologist familiar with the NFP program). The latter was felt to be very helpful. In some instances, CLs or National Unit educators were able to provide reflective supervision for a limited time period.

6. Factors facilitating and impeding the provision of reflective supervision

A number of CLs commented that having reflective supervision embedded into the program and the Core Model Elements is extremely helpful as it illuminates the importance of this element of program implementation. However, there are some factors which make reflective supervision easier or more difficult to manage. The expected role of the NFP supervisor as both operational manager and provider

of Reflective Supervision to the team was seen as helpful but brought some potential tensions, meaning that the supervisor needs to be very skilled to manage this well. Being able to approach positive and challenging performance issues in a strength based collaborative way was seen as an important element of the reflective supervision model that impacted positively on program quality.

Factors which aid the provision of reflective supervision:

- A fully staffed team
- A quiet, private, calm space
- A written supervision agreement
- Appropriate education /training for both parties
- Boundaries are managed
- Clear expectations and goals
- Ensuring that there is a focus on the child (sometimes dolls are used in the room as a reminder of this)
- Nurses feeling that the reflective supervision is for them.
- Nurses' willingness to open themselves up and explore
- Preparation prior to session by both supervisor and nurse
- Structure and regularity of scheduling
- Structured opportunities for the NFP Supervisor to receive reflective supervision herself
- Supervision documents that provide a frame and structure for the process
- Supervisor has a positive attitude and role models the program principles, communication styles and approaches.
- Supervisor manages the relationship ensuring that any ruptures to this are repaired
- Supervisor with an appropriate level of expertise
- Support for reflective supervision at site leadership level
- Use of the Seven-eyed model, which highlights potential areas of exploration

Factors which impede the provision reflective supervision:

- Change of supervisor – as it takes time to build new relationships and trust
- Initial nurse frustration if they are used to an expert model of supervision and expect to be told what to do
- Lack of trust and poor quality of supervisory relationship
- Lack of willingness to engage by nurse or supervisor
- Large travel distances and therefore need to use phone for reflective supervision (although this can work well)
- Sick leave in the team – nurse or supervisor - results in increased workloads and scheduling constraints
- Supervisor and/or nurse having a negative attitude to reflection
- Supervisor having additional organizational commitments that can create conflicts in her availability to provide NFP reflective supervision

- Supervisor or nurse not open to learning and changing
- Supervisors with low levels of confidence, expertise, attitude
- Volume of documentation
- Where supervisors do not adjust their approach for nurses with high levels of experience

Observed home visits:

One fairly unique aspect of the supervisory model in NFP is the expectation that supervisors will observe each NFP nurse in home visits on a 4-monthly basis. These were felt to be a very positive opportunity, where both parties could reflect together on what happened within the visit and why. Supervisors have the unique opportunity to directly observe the natural process between the nurse and client.

The 2016 documentation (provided to all CLs to support this process) when used, was felt to improve confidence and that learning took place from the process, as the nurse was able to agree with the supervisor, prior to the visit, the areas she wishes to focus on in reflection after the event.

Challenges identified regarding completion of these observed home visits (OHVs) included:

- Client anxiety regarding an additional visitor to their home
- Client cancelled visits
- Excessive travel time for supervisor to remote locations
- Lack of skill and confidence of supervisor
- Lack of trust between nurse and supervisor
- Nurse anxiety regarding being observed
- Scheduling challenges/conflicts across a large team
- Situations where clients have experienced a number of changes of nurse (This was harder to avoid where nurses were part time and had smaller caseloads to select clients from)
- Uncertainty for either nurse or supervisor regarding the purpose observed home visits
- Where the process of OHVs is confused with performance appraisal

7. Monitoring quality of reflective supervision

Most informants reported that their country was routinely collecting data regarding fidelity to the Core Model Element expectations of supervision and observed home visit regularity. In addition, most countries make annual site review visits where supervision is highlighted and discussed with teams and managers of the implementing agency.

Monitoring the quality of supervision was felt to be a challenging issue by all informants. Mostly this was done informally by listening to supervisors in educational events, communities of practice and meetings and some CLs mentioned the importance of the “How is it going between us?” tool to enable evaluation of the quality of the supervisory relationship. A number of countries provided individualised mentoring programs to new supervisors over a period of 12-18 months. This allows an opportunity for observation of supervisory practice by an experienced NFP supervisor. Peer arrangements in some countries also

included the expectation of observation of supervision. Having linked team psychologists who provided 1:1 supervision for the supervisors was also felt to be an important element of quality assurance and some countries had made arrangements to support supervisors and nurses where the relationship was in difficulties.

England reported undertaking a quality improvement project which meant that NFP nurses and supervisors provide feedback on the program; this includes questions about quality and frequency of reflective supervision. In addition, England requests sites to return an annual, anonymised summary of observed home visit assessments to the National Unit to help understanding of challenges across the FNP clinical community and provide focus for refresher education.

One CL felt that it was not her role to assess the quality of a supervisor's work – as they are self-regulated professionals and she was not their manager or employer. However, most informants wanted to explore how the quality of reflective supervision could be monitored more effectively as it was seen as such an important element of the program model.

Summary of the Clinical Lead Interviews

All the CLs and educators interviewed in this project were extremely positive about reflective supervision, citing it as vital to the success of program delivery. Although there were some variations in the way that the supervisor role was managed, the model of reflection being used, the division of supervisory tasks, the educational approach and the nursing standards used by countries, the core concepts, approaches and principles in use within reflective supervision had much in common. Variations in length of experience with NFP and National Unit capacity meant that some countries had been able to give this core model element more attention than others.

The following recommendations were suggested by CLs:

- Develop educational DVDs to exemplify the skills of reflective supervision*
- Develop quality assurance processes/tools to assess fidelity and the quality of reflective supervision
- Provide access to appropriate (streamlined) documentation to support reflective supervision
- Provide greater clarity regarding the integration of the different potential functions of supervision into the NFP reflective supervision model
- Provide greater coherence regarding the goals and model of reflective supervision
- Review of expected frequency of observed home visits, or use of video link observation to reduce travel burden for supervisors
- Share approaches to NFP nurse and SV education, and clarifying minimum expectations for this*
- Share learning from the European model of psychological support for supervisors

(*these suggestions were out-of-scope for this project)

All CLs were keen to share their experiences and learn from international colleagues so that reflective supervision can continue to be developed and improved. They expected that as a result of this that NFP nurses' feelings of being valued and supported would be enhanced and their work with clients would also be enriched.

C. SUMMARY OF FINDINGS FROM THE NFP NURSES AND SUPERVISORS QUESTIONNAIRES

Introduction

This summary of the experiences of the NFP supervisors (SVs) and nurses has been prepared based on analysis of data provided from questionnaires received from seven countries: Australia, Bulgaria, Canada, England Northern Ireland, Norway, and Scotland. The United States is in the midst of changing their model of reflective supervision (RS) and therefore felt it would be too confusing for staff to participate directly in this project.

Themes based on the information provided by the participants are identified, with a short summary of the issues presented below. Participant suggestions for mitigation to identified challenges are included wherever possible, along with brief quotes where relevant, to illustrate the issue. The comprehensiveness of the responses varied from country to country with lots of narrative provided in some areas of the questionnaire and very little in others. For many of the themes, the responses from both the NFP nurse and SV were similar or the same. When the themes were different, the responses are summarized separately.

As per the agreed upon process for the project, each country decided on their own method for distribution of the questionnaires, collation, and analysis of the data received. Some used methods such as Survey Monkey to collect and collate the data; others relied on the CLs/nurse educators to collate and analyse the individual responses; and two countries submitted all their data. It is not known if the content of responses was affected by the data generation or analytical processes chosen. Approximately 170 questionnaires were completed by SVs and NFP nurses.

Thematic Analysis

Ten themes emerged from the participants. A short summary of the issues related to each theme are presented below, recommendations from the SVs and NFP nurse are provided, and brief quotes are included where relevant to illuminate the text.

1. **The rewards of engaging in a trusting relationship between the NFP Nurse and Supervisor through reflective supervision:**

Supervisors:

Directly supporting the NFP nurse in her role:

Almost all SVs identified that the most rewarding factor was the opportunity to make the NFP nurse feel supported and nurtured in their role. The importance of 'containment' for the nurse (whereby the SV receives and understands the emotional communication of the nurse without being overwhelmed by it and helps process her emotions) was reiterated by SVs as well as helping the nurse feel valued in her day to day work,

- *"The most rewarding thing is …. containing the nurse and making them feel nurtured, when this is in place, they have space in their mind to reflect on practice." (SV)*

Professional development of the NFP nurse:

Witnessing the nurse grow and develop expertise in areas such as analytical skills and problem solving and seeing the nurses' confidence levels improve was a common response across all countries. The process of RS was seen as an opportunity to jointly identify new learning needs and agree on how they are best met.

NFP Nurse feels safe and gains confidence:

Ensuring that the nurse feels 'safe' in her practice (i.e. through reaffirmation from her SV that she is focusing on the areas she needs to, and addressing client needs effectively) was identified by over half of the respondents as an important contributor to supporting the nurse develop expertise and more confidence in her practice. SVs also shared feedback from the nurses that they felt reassured that their practice had been observed (particularly when they had subsequently received positive feedback). The importance of having protected time and a safe space in which to explore identified issues and help re-focus their priorities was identified by both NFP SVs and nurses as paramount to the process.

- *"Seeing a light bulb moment for the nurse is most rewarding." (SV*)

Opportunity to model the parallel process:

For many SVs, the opportunity to 'walk the talk' through a parallel process was seen to be an important part of the role she plays in the RS process. This was not a common thread in the answers provided by NFP nurses. Where it was referenced by NFP nurses, it was in relation to the negative impact of the SV not using the parallel process. Agenda-matching to agree on the content for discussion was noted as important by a large number of SVs and NFP nurses.

NFP Nurses

Gaining support for their NFP role:

The responses from NFP nurses mirrored that of the SVs in that RS was an opportunity for them to gain support for the role and not feel alone. RS was seen to deepen client understanding as it led to a feeling of not 'standing alone' i.e. there was someone working alongside her to address complex situations thus preventing the feeling of being overwhelmed by the emotional challenges of the work.

- *"It [reflective supervision] is a debrief which allows me to synthesise large amounts of information." (NFP nurse)*

Non-judgemental support:

Most NFP nurses referred to the process of RS as an opportunity to learn and develop through a constructive and strength-based approach.

- *"It is about not being judged; it is about being listened to without judgement." (NFP nurse)*

2. The most important goals of reflective supervision in NFP

Support with expert decision making in order to improve practice:

Both SVs and NFP nurses identified the same goals of RS. All shared that RS is about overall support to the nurse with optimal decision making through the provision of a 'safe-space' and environment to discuss challenging or complex issues. The importance of a trusting relationship between the two practitioners was a common thread throughout many responses across almost all countries to this question. This trusting relationship mirrored that of nurse and client.

Program Quality Assurance:

The overall quality of NFP and the importance of considering the program outcomes was frequently cited. RS is seen to help both the NFP nurse and SV in achieving program goals. Examples of *how* included:

- Being closer to the client and family
- Boundary setting
- Exploring bias
- Having an extra perspective i.e. "two eyes"
- Helping develop emotional resilience

Safeguarding/child protection:

Almost all of the countries who have been implementing the program for over five years have a higher priority to 'safeguarding' or child protection as a RS goal in NFP. SVs tended to list safeguarding and child protection as a key goal more than NFP nurses. The newer implementing countries focused more on RS being about 'emotional' support for the nurse and ensuring their well-being. The focus was less on program outcomes or wider public health gains for these countries. This is likely to be part of the 'evolutionary' process of understanding NFP and its potential impact.

- *"RS is being able to explore issues around child protection at a deeper level" (SV)*

Development of the NFP nurse:

The process of assisting the NFP nurse to come to decisions herself in managing her caseload was important to the SVs. The 'style' of the SV was important was also important in helping the nurse

become confident in managing her work. SVs saw RS as the place to build confidence through the development of analytical skills and the clinical application of program tools such as DANCE and PIPE.

3. Factors that facilitate or impede the process of reflective supervision

A trusting and honest relationship between SV and NFP nurse:

Several respondents described the RS relationship as similar to that between nurse and client. Some described it as 'mirroring' this relationship while others used the term 'therapeutic' to describe a respectful, honest, non-directive, and solution-focused relationship. Having a trusting relationship between the SV and nurse was identified as the main factor to enhance (or inhibit) RS. The importance of being able to be open and honest and ideally 'agenda match' with each other was also important. Overall, the responses reflected robust relationships between SVs and NFP nurses across most countries, allowing the process of RS to be dynamic and meaningful. A small number of respondents reported the supervisor-nurse relationship was not strong/trusting and they all felt negatively towards the RS process *as a whole* and listed its potential negative impact on them as practitioners.

- "[Nurses need] ….*a supportive and reflective supervisor who listens and does not lecture you or make you feel guilty or bad at your job." (NFP nurse)*

Preparation/prioritizing reflective supervision:

The importance of good organization/preparation for each RS session, space in a private setting, without interruptions, and having a consistent/regular time in the SVs' and nurses' diaries/calendars was paramount to success. Not making RS a priority because of workload or competing priorities (by either SV or nurse) was seen as the main factor in inhibiting its effectiveness in promoting best practice

- *"Being prepared for the session…in a calm and quiet place with no interruption is essential" (NFP Nurse)*

Knowledge and competence of Supervisor in providing reflective supervision:

A SV who is fully conversant with both process and is 'emotionally available' to the NFP nurse was highlighted as a significant factor in enhancing RS.

- *"The supervisor should be contained, receptive, and well trained in the use of models of supervision." (NFP nurse)*

A SV who is able to give positive regard and identify easily the strengths of the nurse was considered important. Simultaneously, an SV who is skilful in being able to keep the focus 'on the child' was considered an asset to the facilitation process.

Use of supervision tools:

The use of Hawkins and Shohet's Seven-eyed model and Kolb reflective cycle were most frequently referenced as being helpful to RS. The work of Kadushin and Proctor were also identified as helpful to the process.

Environmental issues:

In some of the countries where travel is a challenge, descriptions were included that outlined significant clinical time being lost for both SV and nurse due to the sheer challenge of getting to a location. A small number of respondents described the importance of face- to-face supervision even if it is only occasional. This was an obvious challenge for the geographically larger implementing countries.

Fidelity data/client outcome reports:

Nurses and SVs in only two countries mentioned the importance of reviewing fidelity data/client outcome reports during RS. Few examples were shared on how it can help shape discussions in the process of RS.

Additional comments related to how RS should make the NFP nurse feel; RS process should *"make a nurse grow in confidence", "be an enhancing process"* and *"the nurse should feel better because of it"* (NFP nurses)

4. The areas of work/issues reflected on within the supervision process

- A large number of SVs and NFP nurses cited Hawkins and Shohet's Seven-eyed model as the tool used to focus discussion (see Appendix A)
- Almost all countries implementing the program for more than five years, placed safeguarding/child protection higher as an area for reflection.
- Many SVs included the learning needs of the NFP nurse:
  - *"We also discuss professional development supporting learning and development of new knowledge and skills." (SV)*
- The majority of SVs and NFP nurses described the importance of the discussions being 'led' by the nurse, and clinical objectives shaped jointly through the RS process, nicely illustrated by this SV
  - *"We discuss issues where a visceral response occurs for the nurse (positive and negative)." (SV)*
- Other examples included:
  - Local neighbourhood issues affecting families
  - New NFP program materials and their use
  - Personal issues impeding practice
  - Positive stories around outcomes for clients
  - Team dynamics

5. **The impact reflective supervision has on the quality of NFP program.**

Delivering the program with excellence:

Responses from all respondents focused on the sharing of ideas, collective problem solving, and looking at different ways to work with clients, so improving the overall outcomes for clients. RS was described

by SVs as being helpful in preventing program drift i.e. a deviation from the NFP model. It provides an opportunity to check-in to confirm that the NFP nurse is working and practicing within the guidelines of the program. It was also described by some as an opportunity to check on her well-being and support her to on-load ideas or off-load anxieties about her practice. The quality of the supervisory relationship was seen as key to supporting this 'on-off loading' process.

- *" Its [RS] existence is paramount to the success; delivery of the NFP/FNP program." (SV)*

RS also impacts positively on the quality of practice related to safeguarding and protecting mothers & children. Increased vigilance and safety were frequently noted resulting in:

- *"Less blind spots for NFP nurses"* (SV)
- *"The baby is always placed first"* (NFP nurse)

Nurse education and development:

RS was considered to assist the nurse further develop her clinical competences, thus enhancing potential outcomes for her clients. Both NFP nurses and SVs discussed RS as being helpful for the practical application of new skills. Discussion between the two helped identify other tools for the nurse to draw upon, enabling the nurse to function at a more expert level.

- "*I have been able to transfer some of the skills used with some clients and use them with others". (NFP nurse)*
- *"All family nurses are skilled practitioners. The added value of RS gives an objectivity to consider what next for their clients. It helps them unpick difficult situations and consider what else might be going on and what might help."* (SV)
- "*Helps me identify areas where I can update knowledge or study at a higher level"* (NFP nurse)
- *"Supports individual learning about the program materials.*" (NFP nurse)

Wider impact:

Respondents from two countries in particular, were able to see the wider reaching benefits of RS. They identified public health issues such as smoking and positive outcomes for children and adults who have previously been cared for by the state.

Personal impact of reflective supervision:

NFP nurses' responses tended to be more related to the personal impact RS has for them directly in improving the quality of delivering the program.

- *"Supervision has a tremendous positive impact on my ability to deliver the program in the best possible way due to feeling valued, supported and having to set some time aside to review cases."* (NFP nurse)
- *"The guidance (both individual and group) has a major impact on my work. It works both as a container function/ having an outlet for feelings, it builds self-confidence in my work with the clients…"* (NFP nurse)
- *"It can make or break me. It impacts on my emotional availability to deliver the program.*" (NFP nurse)

- *"RS allows the FN to feel contained and safe and enables him/her to model that with the clients"* (SV)

6. Other supervision undertaken.

Almost half of the NFP SVs and nurses identified safeguarding /child protection supervision as an enhancement to their NFP reflective supervision experiences. It was highly valued and considered necessary for their NFP role. Several countries reported having a clinical psychologist work directly with the team and the SV. This was also reported as extremely valuable to both SV and NFP nurse. This is an enhancement to the original NFP model and is provided in Bulgaria, England, Norway, Northern Ireland and Scotland.

The NFP supervision process in some sites is 'split' in that other practitioners, mainly referred to as a 'manager' are involved in the process of supporting the nurse. The approach used by the manager was not always consistent with the NFP RS approach. It appeared from the responses that the manager's style is more directive than guiding. It was not clear from the responses where accountability for NFP nurse clinical performance lay in these situations.

Other additional methods/types of supervision listed included:

- Case conferencing
- Child welfare supervision
- Head of teams (Psychology)
- Peer supervision
- Public Health Agency
- Specialist supervision for staff who are qualified counsellors
- Specialist support from Social Workers
- Team supervision
- Tripartite (child protection) supervision where a specialist practitioner who works with vulnerable children and families joins the SV and nurse to discuss cases and collectively agree on a course of action

Note: Responses did not elaborate further on describing these supervision methods or how they were implemented. The frequency of these supervision sessions ranged from weekly to monthly.

7. Support and education received to ensure that the purpose of NFP reflective supervision is understood.

Responses from both SV and NFP nurses predominantly focused on training, referred to as core or mandatory NFP education that takes place when the nurses are new to NFP. Very few responses referred to any ongoing continuous professional development opportunities for updating skills in RS.

For some NFP nurses the actual meeting for RS with the SV was considered an opportunity to ensure that they understood about RS.

- *"Through regular weekly supervision, training and support from supervisor*" (NFP nurse)

It seemed that the process of the NFP nurse and SV meeting, was also used as an opportunity to discuss RS and its application to practice. Some SVs cited the role of the psychologist in supporting their understanding of RS but did not elaborate on whether this was through 1;1 supervision or through formal education.

Other areas identified included:

- Face-to-face education about RS and its application
- Higher education; accessed further study
- Meetings with the International Consultant
- Reading
- Shadowing others
- Specialist training such as a safeguarding expert who focused specifically on RS
- You Tube

8. Benefits and challenges of observed home visits

The majority of NFP SV and nurses agreed on the benefits and challenges of Observed Home Visits (OHVs). Almost all found OHVs beneficial for the client, the SV (observer), and the nurse. A very small number of NFP nurses did not find them helpful and did not feel that they improved practice. This appeared to correlate when there was a breakdown or poor relationship with the SV. When trust had gone, being observed by a SV had an extremely negative impact for the small number who did not value undertaking of the OHVs.

Observe and inform practice:

- Enables evaluation of the content and quality of activity undertaken by the nurse and assists in the nurse setting goals jointly with the client
- Helps ensure effective replication of NFP
- Offers guidance to nurse by SV being "a second pair of eyes"
- Provides constructive affirmation and feedback to the nurse
- Supports the SV to see real client interaction and a potential to improve their own (SV) clinical skills (particularly where SV does not carry a caseload)
- The NFP nurse gains confidence from knowing SV is aware of NFP nurse skills
- The SV gains a wider picture of challenges (for NFP nurse) to implementing the program
- *"[Observed home visits are] an opportunity to observe the quality and integrity of program delivery"* (SV)

Ensure the quality of the nurse client relationship:

- Enables an opportunity to evaluate the level of family engagement in services

- Provides an opportunity for the client to share how she feels about the support she is receiving
- Provides an opportunity to jointly evaluate quality of nurse-client relationship.
- Reassures the client that the NFP nurse is being supported to be effective in the role
- Supports SV to see the challenges that the nurse may be facing and assist in problem solving and setting goals
  - *"It is beneficial to get feedback and that I am delivering NFP effectively and in a strength-based way."* (NFP nurse)

Stressful environment:

Challenges:

- For some NFP nurses the creation of a 'stressful environment' through being observed within a visit was identified as a challenge. Examples included: clients feeling self-conscious; the nurse feeling stressed about being observed; and the artificial set up of the visit with an observer present.
- The "Hawthorne Effect" where behaviours are altered because of being observed was a common theme.

Suggested mitigation strategies:

- Knowing your caseload well so that clients could be carefully chosen to avoid unnecessary stress, ensuring clear client consent or permission, and a pre-visit to reassure the client of the reason for OHV (i.e. that it is not about them being assessed or the nurse being monitored).
- Some NFP nurses undertook role play in advance of the visit with the team to overcome their anxieties. SVs prepared the NFP nurse through advance RS sessions reassuring that they were there to discover strengths with the aim of *"…. being proactive in sharing practice."* (SV)
- Many SVs listed the importance of agenda matching with the NFP nurse in advance of the visit and together agreeing on what areas would be helpful to observe to minimize angst.
- *Not* taking notes throughout the session, being aware of body language, and being aware of behaviours such as unnatural silences.
- Some SVs stated the importance of being aware of where they sat in relation to the client and NFP nurse, mindful of the impact of positional power in the home.

Cancelled visits:

Challenges:

- Cancelled visits are one of the most significant themes identified by most respondents and for SVs travelling long distances this is described as particularly challenging given that the time invested in preparation as well as travel is costly.

Suggested mitigation strategies:

- Planning well ahead and reminding clients of the joint visit planned.
- Having a back-up/reserve client was also a strategy used by some NFP nurses to maximise the opportunity of OHVs when a late cancellation was received.

Other challenges:

A small number of nurses felt that OHVs are more relevant to supporting best practice at the beginning versus later in the NFP nurse's career. As the nurse becomes more experienced/skilled, OHVs were considered less useful and is was suggested that a titration or STAR approach should be used i.e. SV and NFP nurse agree on a flexible approach to scheduling OHVs. It was felt that the frequency of OHVs should be adjusted based on skill level to make more effective use of time. For a small number of NFP nurses, the skills of the SV were questioned related to her ability to listen, be non-directive, and identify the strengths of the nurse when assessing the OHV. This therefore undermined the potential benefits of OHVs for these NFP nurses. Two respondents questioned the need for OHVs when other professionals in their country undertaking home visits (as part of a home visiting programme) are not required to.

9. Recommended changes to the model of NFP supervision and other comments

The majority of NFP nurses and SVs who answered this question agreed that no change was needed to the current model and that implementing the program with integrity would not be possible without RS. It is clear that in four countries staff believe that RS is deeply embedded in clinical practice, well led by SVs, and is highly valued by NFP nurses. These countries are exemplars and would be well placed to support others wanting to develop a deeper understanding of RS.
"I wouldn't make any changes –Supervision is highly valued by both NFP nurse and Supervisor" (SV)
Enhancement to learning and development:

With a reported dearth of NFP-specific RS learning resources, many respondents requested the development of more educational materials, stating that the current ones were extremely useful but that more are required to support continuous learning. It was suggested that these resources could also have a wide applicability to other professionals working with children and families. Several proposed the establishment of a national forum for RS with the aim being to balance 'reflection' with clinical performance. Continuous professional development support for goal setting in RS was a key priority for two countries in particular. It was not expanded on in great detail but was mentioned frequently enough to warrant further exploration.

Simplifying the administration; recording and paperwork:

It was reported that there is variation around documentation within and across sites as well as across countries. Respondents stated that a standardized approach to documentation would be welcomed. Little mention was made regarding the quality assurance process and documentation for ensuring RS is implemented as well as measuring its impact on client care.

Flexible approach to conducting Observed Home Visits:

A small number of NFP nurses asked that a more flexible approach regarding the frequency and expectation for OHVs is considered.

- This request appeared to emerge from situations where there was not a trusting relationship between the NFP nurse and supervisor and/or the purpose/benefit of the OHVs were unclear.

Exploring the use of telehealth to conduct reflective supervision:

Respondents suggested the use of telehealth for RS be evaluated in order to determine its effectiveness compared with in-person RS.

Sharing the learning:

Respondents requested that countries where RS is deeply embedded in NFP practice, share their knowledge/experience with the use of RS and their experiences with other countries where it is less well-developed. This was proposed by countries had who had worked with other countries to share learning around RS. Two countries expressed a desire to also share their learning regarding NFP RS with professionals who work alongside them in supporting families.

Increasing the focus on the restorative function during reflective supervision

An increased focus on the restorative element for NFP nurses was identified by a large number of respondents, but no specifics were provided.

Supervisors carrying a caseload/working directly with clients:

A very small number of NFP nurses in one country, felt the clinical credibility of the SV could be enhanced by her working directly with clients to understand the program in a greater depth and so be more effective in RS. This was not an area referred to by SVs. Although small in number (probably because in most countries NFP supervisors have a small clinical caseload), these responses provided an indication of the importance of this issue in the context of RS.

Seeking input from NFP nurses and SVs:

Many respondents used the comments section to provide feedback regarding how positive they felt about being asked their opinions and recognised the importance of the feedback loop. They felt this mirrored the approach used with the client, where their feedback helps constantly improve how the program is delivered.

COLLATED FINDINGS

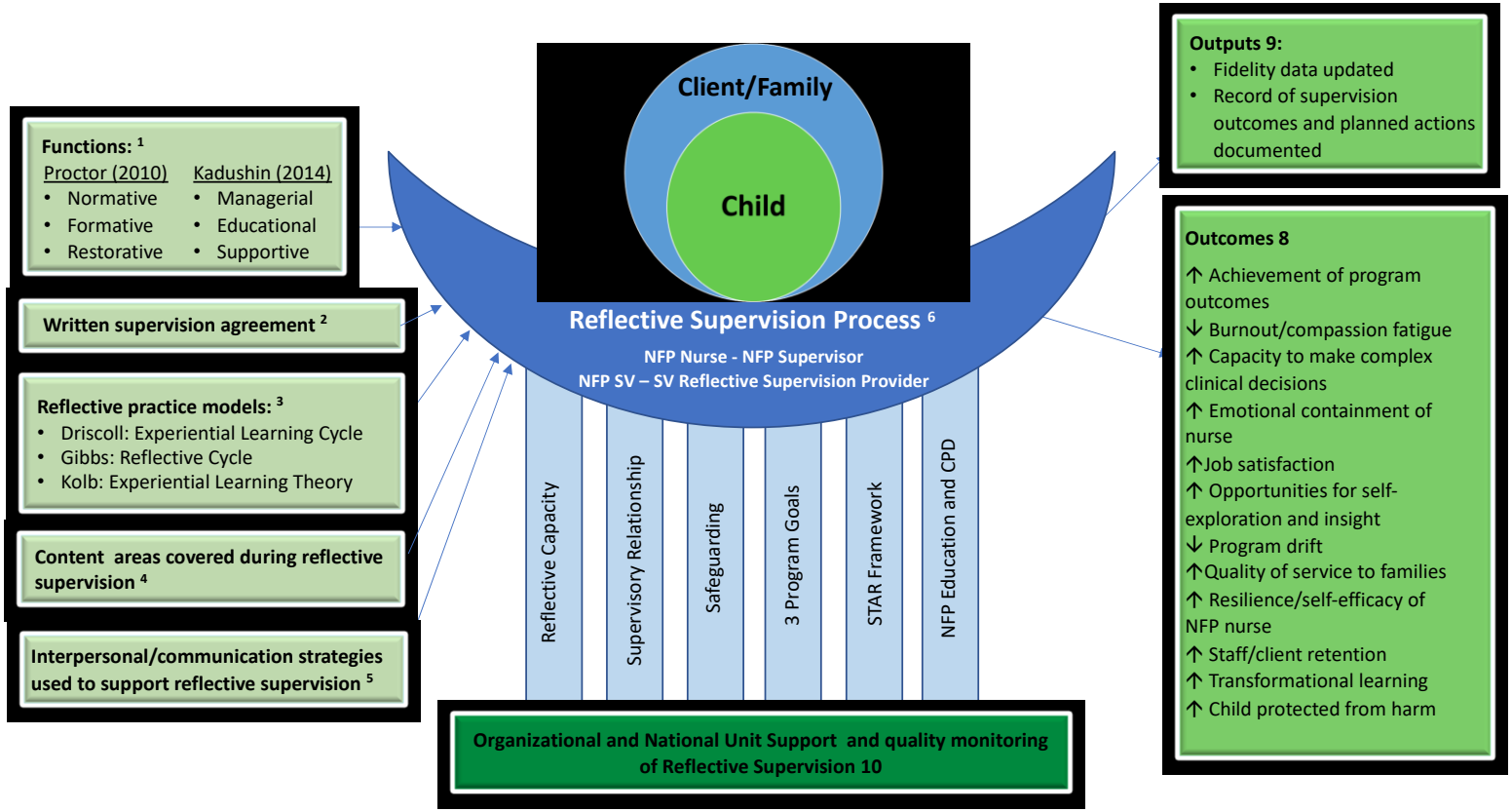
This section of the report aims to bring together the findings from the three data sources utilised to explore reflective supervision in NFP; the literature review, the CL telephone interviews and the NFP nurse and SV survey.

Overall there was a lot of commonality regarding the value, core components and purpose of reflective supervision in the literature and the data collected within this project. Reflective Supervision is seen as integral to the effective delivery of NFP across all countries. The level of knowledge around the process, content and approach to RS was extremely high and showed that RS in NFP implementation is both embraced and understood. The comments regarding inhibiting and enhancing RS mirrored the international literature findings but were able to add an enhanced understanding around practical measures that can be taken to improve the process even further. Where RS is *no*t seen as a vehicle to

improve the delivery of NFP, it focused predominantly around the relationship between SV and NFP nurse rather than process. This had been addressed in some countries through the use of an explicit 'contract' between the two practitioners and further exploration as to what to do when things aren't going well between SV and NFP nurse and where trust has been lost.

As a result of these findings, the International Team is proposing an NFP reflective model that incorporates the key elements revealed in this work. The model is outlined and described below:

NFP REFLECTIVE SUPERVISION FRAMEWORK



*The **purpose** of NFP reflective supervision is to enable participants to learn and continually refine their professional skills, fostering insightfulness, supported by a collaborative, respectful, trusting relationship between nurse and supervisor. Using the parallel process, it focuses on the development of skills, knowledge, attitudes; client engagement and safety; high quality service to the client/family, containment of the nurse; and achieving the three NFP program goals.*

Components of NFP Reflective Supervision Framework

More detail regarding each component of this framework is set out below:

1. Functions:
   The reflective supervision approach used by each country should clearly reflect the three different functions of supervision identified by Proctor[68] and Kadushin.[69]
   - Restorative/Supportive function: Gives attention to the emotional needs of the NFP nurse, how they have been affected by the work, and how to deal with these feelings constructively.[70]
   - Formative/Educational function: Focuses on developing skills, understanding and ability, by reflecting on and exploring the work of the person being supervised. This includes supporting the integration of different elements of the program model.
   - Normative/Managerial function: A key element of ensuring that the professional standards and professional/ organizational roles are met; a quality-control function (including preventing program drift). This would include review of data reports to shape discussion in reflective supervision.

2. Written supervision agreement:
   - A written reflective supervision agreement/contract should be drawn up jointly at the beginning of every supervisory relationship, clarifying the NFP expectations for reflective supervision, it's purpose, and benefits.
   - There are eight key areas that should be included in the agreement: 1) clarifying the roles, responsibilities and professional accountabilities of NFP Nurses and Supervisors as they participate in Reflective Supervision; 2) agreeing on practicalities (scheduling, place, frequency, documentation etc.); 3) establishing clear boundaries related to confidentiality; 4) sharing mutual expectations that work towards establishing trust, respect, and an effective working alliance; 5) clarifying any expectations the organization may have related to reflective supervision; 6) clarifying the session format , including how the nurse and supervisor will prepare for the session, agenda matching expectations, content expectations; how often cases will be reviewed; how often fidelity/client outcome data reports will be reviewed; format for presenting cases etc.; 7) how the reflective supervision session will be recorded; and 8) a section regarding "What will we do if there are difficulties working together." This should include processes to resolve any issues that cannot be resolved by the nurse and supervisor alone. These recommendations are adapted from Hawkins and Shohet, 2012.[71]
   - We recommend adapting the NFP facilitator "How is it Going Between Us" or developing a similar document for the Nurse and Supervisor to use to assess how reflective supervision is working between them periodically.
   - The supervision agreement is reviewed/updated at least annually and as needed.

3. Reflective practice models:
    - A reflective practice model will be used within reflective supervision to guide exploration, reflection and analysis of the content brought to supervision (see item 4), with plans developed and agreed as a result.
    - Each country will choose between the three reflective practice models in use in NFP (Kolb, Gibbs and Driscoll) they feel best fits their unique context.
    - Use of the reflective practice model within reflective supervision should be covered in NFP nurse and supervisor core education sessions and it is recommended that opportunities for further exploration of this are provided through Continuous Professional Development (CPD) as nurses and supervisors gain experience.

4. Content areas covered during reflective supervision:

The content of each RS session should be agreed through a process of agenda matching between the NFP nurse and supervisor. Both NFP nurse and supervisor should prepare for the supervision session beforehand with reference both to plans made in previous sessions and priority issues of the moment. The nurses' agenda should mostly be prioritised. However, it is expected that the content should include all the elements listed below over time:

- Using the STAR framework (or equivalent) to review priority areas to focus on with the client and assess any needed adaptations of the program. This would include:
    - Exploring the client's situation and safety, engagement in the program, and progress towards achieving their personal and program goals
    - Exploring the child's experiences which are distinct from the client or other family members. Some countries ask the question "if the child could speak, how would he/she say life was like for her/him in this family?" This focusses attention on the child's wellbeing and experiences within the family and community, encouraging a concern for child safety/protection issues to be considered.
- Exploring the nurse's experiences (including use of NFP model and materials) and the successes and challenges the nurse is experiencing with both use of the program model and enabling change and progress with clients.
- Exploring the nurse's relationships with: client/family, her supervisor, NFP team, and wider context
- Exploring what was experienced and observed during joint home visits. This provides an opportunity for joint reflection on the visit in a collaborative, strength-based and dynamic way. This reflection supports a deeper understanding of observed family dynamics and relationships. It also enables exploration/assessment of the nurse's clinical practice.
- Reviewing fidelity and/or client outcome data reports to reflect on trends and patterns, both for individual clients or across caseloads. This reflection on practice: identifies areas of strength and any areas requiring attention/improvement; prevents program "drift"; and strengthens clinical practice

- Reviewing recent educational experiences to ensure understanding and support the integration and application of this new learning into everyday practice.
- Reviewing nurse performance and progress in the NFP role, including competency development.

These recommendations are adapted from Hawkins and Shohet, 2012.[72]

5. Interpersonal/communication strategies used to support reflective supervision:
   A range of communication strategies need to be employed by the supervisor to ensure a positive reflective space for supervision. An important element of this is to model the program approaches through a parallel process. This provides an opportunity for the NFP nurse to experience a supportive, non-judgmental, trusting relationship as it is role-modelled by the supervisor. The nurse is then able to re-create this process to develop a therapeutic relationship with her clients. The parallel process "Describes the interlocking network of relationships between supervisor, supervisees, families, and children" (Heffron & Murch, 2010, pg. 9).

   Other strategies (drawn from the literature, in particular Ladany et al., 2013; [73] and Wallbank & Wonnacut, 2015.[74]) include:

Strategy	Approach by the supervisor:
Encourage autonomy	Encourages the nurse's self-directed decision making and performance as well as self-reflection and independent thinking.
Strength based	Provides affirmations, feedback, and reinforcement in order to increase the nurse's confidence and competence to deliver the NFP program skillfully.
Active listening	Uses MI skills (especially OARS) to support accurate recall of events and nurse reflection
Promote formal reflection	Uses a reflective practice structure that supports formal reflection, analysis and the development of plans. The supervisor challenges assumptions and biases driving practice.
Provide constructive challenges	Challenges the NFP nurse to go beyond her comfort zone. This may include use of elements of the program model that the nurse is less comfortable with.
Create emotional safety	Creates a positive, trusting relationship/alliance in which emotional safety is created to facilitate the exploration of difficult feelings, progress towards achieving goals. This process, sometimes referred to as "containment" or "emotional regulation", supports and fortifies the NFP nurse to continue working with their complex families even when progress is slow or appears stalled.

Foster resilience	Supports the NFP nurse in exploring any feelings, distress, anger, role conflict, or unhappiness in working with clients/NFP program using an empathetic, non-judgmental approach. The aim is to enhance the capacity of the nurse to remain resilient, feel restored, and to recognize personal triggers, when working with clients/families who have many complex issues.
Encourage use of support systems	Guides/encourages the NFP nurse to build positive relationship with her team members and engage with other service providers in order to avoid feeling isolated in her NFP work. The supervisor assesses for any signs of vicarious trauma and/or compassion fatigue and intervenes as appropriate.
Support development of clinical knowledge and skills	Provides specific guidance related to implementing the NFP model and promotes increased confidence and competence of the nurse through development of her knowledge and skills.
Support analysis and critical thinking	Guides/encourages the NFP nurse to question her practice, critically analyze and evaluate her experiences, and debrief (formally and informally) after challenging or stressful work-related encounters. The intent is to support the nurse to a better understand the cognitive and emotional elements of her NFP practice.

6. Reflective supervision process:
    - The regularity and process of reflective 1:1 supervision should be maintained in line with CME #12 and this NFP Reflective Supervision framework.
    - It is essential that NFP supervisors also participate in reflective supervision with someone knowledgeable about NFP and clinical issues that may arise. Each country will determine the frequency of reflective supervision provided to supervisors, however the approach used should be consistent to that for NFP nurses.

7. Six pillars to support reflective supervision:
    - **Reflective Capacity**: The NFP nurse must be aware of her own personal thoughts, feelings, beliefs, and attitudes; understand how these practices affect her behaviours and responses when interacting with others (client/family, team, and wider context). She must also be willing and able to commit to exploration, reflection, and accept challenges.
    - **Supervisory Relationship**: The NFP nurse and supervisor must mutually commit to a collaborative, regular, honest, safe, consistent, respectful, confidential, and dependable relationship.[75] Participants should feel safe to think, feel and reflect. Any challenges to the relationship should be openly discussed and addressed by use of the contract and associated materials. Effective supervisors:[76]
        - Display a positive attitude towards, and active involvement in, supervision

- Display positive personal characteristics that facilitate supervision, as well as professional qualities that serve as a model or positive influence for the NFP nurse.
- Display support, encouragement, acceptance, respect, trust, empathy, open-mindedness, and other behaviours that contribute to the development of a positive supervisory relationship.
- Demonstrate clinical knowledge and skills related to NFP. Having current clinical experience of program delivery enhances this aspect.

- **Safeguarding**: Paying particular attention to the child's experiences within the family as a central component of reflective supervision enables the child's needs and safety to be specifically attended to, with the goal of preventing child maltreatment and intervening early when there are safeguarding concerns. The essence of a good safeguarding supervision is supporting the capacity of the practitioner to think, reflect and develop their own solutions around what needs to happen next with families.[77] NFP teams should have access to externally run, structured and intensive debriefing sessions for staff following serious safeguarding and other critical incidents.
- **Program goals**: The NFP nurse and supervisor pay attention to the extent to which the NFP nurses' actions/use of the NFP program model are supporting the client's progress in the achievement of the three NFP program and any individual goals.
- **(Strength and Risks) STAR Framework**: The findings from the client's STAR (or its equivalent) is used to explore and guide the NFP nurse's understanding of the client/family strengths, risks, and attributes and supports nurses to prioritise and individualise activities in relation to specific client needs.
- **NFP Learning and Education**: Specific content and skill building regarding reflective supervision must be built into the core education curriculum and ongoing phase of NFP education to ensure NFP nurses and supervisors have the knowledge, skills, and ability to commit to the reflective supervision model and process.

8. Expected outcomes of reflective supervision

- The expected outcomes of the RS framework are derived from the data generated within this project
- The supervisor should keep these expected outcomes in mind as she undertakes RS and reflect on her impact on the supervisory process as part of her ongoing reflective supervision.
- It is expected that countries will develop an evaluative process for monitoring both the process and selected outcomes over time.

9. Expected outputs from reflective supervision

A number of products are expected to arise from each RS session. These should include:

- *Data monitoring for fidelity to CME #12*
  This will include at minimum a record of the regularity and length of supervision undertaken. Countries may also wish to include a summary of topics explored in RS as this will enable analysis of the extent to which SVs are exploring the range of content areas included in this

framework.

- *Records of analysis and plans for clients and families discussed in Reflective Supervision* When focused on clients and families, NFP nurses and supervisors should utilize the STAR framework (or equivalent) as the starting point for reflection and analysis. It is expected that through reflective supervision plans and priorities for the nurses work with families are agreed. These should be recorded in line with the country's usual NFP clinical record keeping processes.
- *Records of the RS process, outcomes and plans for NFP supervisor and nurse.* There should be a record of the non-client focused elements of the RS process, with any decisions, plans and expected actions recorded.

Countries may should also consider whether they develop a *record of the content of supervision*. This would include all non-client issues, such as nurse progress and challenges in delivery of the program. It is important to note that agreement should be reached regarding the boundaries of RS documentation so that nurses continue to feel safe to share their feelings and responses to their work, without feeling that these will be inappropriately documented. Consideration should be given to storage of these records in line with local information governance processes.

10. Organizational and National Unit (NU)/National Implementation Team (NIT) Support for Reflective Supervision
    - NFP supervisors should be carefully selected through a robust recruitment process. Many countries have found that client involvement in this recruitment adds an important dimension in ensuring the right appointments are made.
    - The education process should ensure that that Supervisors are able to develop the capability required for this complex role. Including RS in any Continuous Professional Development model will also ensure that learning is continuous and that the process remains dynamic.
    - NFP supervisors must have the support of their organization's decision-makers so that policies and procedures are put in place to ensure that high quality reflective supervision occurs that meets the fidelity requirements laid out in Core Model Element #12.
    - Countries should implement quality monitoring processes to evaluate the quality and effectiveness of reflective supervision and develop improvement measures to address any challenges.
    - National leaders of each country should ensure that local implementing organizations/sites understand the importance and benefits/outcomes of this NFP Core Model Element. The license holder is accountable for ensuring processes are in place to monitor and report on fidelity to this CME.
    - The country's NU/NIT and the relevant decision-maker(s) from the NFP sites should agree on who will deliver NFP-focused reflective supervision to the supervisors and the expected regularity of this.
    - The country's NU/NIT should provide comprehensive core and ongoing education focused on achieving the delivery of high-quality reflective supervision to both NFP nurses and supervisors.

DISCUSSION

A number of issues arose during this project that are outside the scope of the new NFP Reflective Supervision Framework described above. These are discussed briefly below:

Scope of NFP supervisor role:

The scope of the supervisor role was discussed by many participants in this project. A number of issues in relation to this arose for a minority of countries:

- ***Supervisors providing supervision for non-NFP staff***
  Some NFP supervisors were also providing supervision to other non-NFP clinicians, including practitioners working in other programs. This creates a challenge in terms of time, role distinction and the ability to adhere to the NFP Reflective supervision framework.

  If this cannot be avoided, we would recommend that due consideration is given to evaluating and mitigating for any adverse impacts on the quality of RS within NFP.

- ***NFP nurses receiving managerial support/ supervision from others in the organization***
  In a minority of countries, the content areas of reflective supervision were separated, so that reflection on nurse performance and development were carried out by non-NFP supervisors. One informant in this project, working in a situation where the managerial and supervisory aspects of the NFP supervisor were undertaken by different individuals, described the accountabilities of all players as a bit of a 'grey area', where there was the potential for responsibilities for nurse performance falling between these roles and therefore not being attended to. In contrast to this, most informants were positive about the holistic nature of the NFP supervisor role, feeling that exploring nurse performance in reflective supervision provided opportunities for professional growth and meant that accountability for the whole team's delivery of the program was transparent.

  The text supporting CME #12 clarifies this as it states: *"In addition to carrying out supervision, the supervisor will; manage the team, develop and sustain NFP implementation and client recruitment, guide the nurses' learning, lead quality improvement initiatives and represent the program within the local community".*

- ***SVs not having experience of clinical practice in NFP***

  In some countries, supervisors do not have a caseload of clients. In this project we heard that this causes challenges to the SV's clinical credibility with NFP nurses, as well as the depth of her understanding of the program.

  The text supporting CME #12 states: *"It is recommended that where possible, the supervisor carry a small caseload of clients in order to maintain their understanding of the clinical issues of the program."*

  This project has reinforced the importance of program leaders facilitating this in their country wherever possible.

- ***Supervision of NFP associate staff team members***

In two countries, additional NFP team members have been incorporated into the model, primarily in order to enhance program delivery for indigenous or minority communities being served. This project did not examine the experiences of supervisors or practitioners in these circumstances. However, it can be expected that the benefits of RS identified during this project will also be experienced by other NFP practitioners. This reinforces the decision taken by the countries with these roles to implement reflective supervision for these practitioners and we look forward to developing this aspect of RS more fully in the future with these countries.

Observed home visits

As will have been noted, most respondents in this project were very positive about the potential benefits of OHVs. The text supporting CME #12 states: "*Every 4 months the supervisor makes an observation visit with each nurse to at least one client and additional visits on an as needed basis at the nurse or supervisor's request. Joint reflection on the visit can support a deeper understanding of observed family dynamics and relationships as well as enable exploration of the nurse's clinical practice".*

Other issues emerging were:

- *A request for flex in regularity (less frequent OHVs for experienced nurses).*
  This was suggested by nurses in one country specifically. However, there was sufficient positive feedback from most informants for us to continue to have confidence that the expected frequency of OHVs is helpful. However, we would advise that clinical leads give some attention to exploring this issue with experienced practitioners with a view to better understanding and elaborating how OHVs can especially support experienced practitioners.

- *The importance of contingency plans in anticipation of failed OHVs*
  The time lost from client unavailability for OHVs, often at very short notice, means that having 'back up' plans, as suggested by some informants, are of great importance.

- *Dynamics between observed and observer*
  OHVs were stated to be at their most productive when the relationship between NFP nurse and SV was trusting and respectful. An appreciation of the challenges in being observed for nurses and open discussion regarding the wishes of both parties was said to minimize these. It was also clear that the SV being unobtrusive within the visit, showing respect for the client – nurse interaction enhanced the experience and potential for learning.

Quality monitoring

One of the biggest challenges for all countries was assessing the quality of reflective supervision being undertaken by NFP supervisors and nurses. Monitoring regularity, length and content of supervision affords some reassurance of quality, but this is limited.

Some countries have been able to address this through peer observation (supervisor to supervisor) with guided reflective feedback. However, for countries that are geographically dispersed, this approach holds many challenges. Where this is the case, regular feedback from nurses and supervisors in the form of surveys would give some indication of quality and areas of challenge to be addressed

Documentation

All countries reported some challenges with appropriate documentation for RS. This was seen as burdensome and not necessarily enhancing or supporting the reflective supervisory process. This is addressed to some extent within the 'outputs' element of the proposed NFP reflective supervision framework (see p 31). Whilst the fidelity documentation is relatively straightforward, there are significant variations in the requirements in relation to clinical record keeping and information governance across countries which may mean that it is not possible to develop one template that meets all requirements. It is also important to note that agreement should be reached regarding the boundaries of RS documentation so that nurses continue to feel safe to share their feelings and responses to their work, without feeling that these will be inappropriately documented.

Additional Supervision expectations

In some countries, nurses reported undertaking additional supervision, in addition to their NFP RS. This may be disruptive if it challenges the authority of the NFP supervisor. It would be helpful for Clinical leads to be clear about the added value of this supervision to the nurses' practice and develop protocols to ensure integration of all expected supervision.

Education and CPD

Clearly a lot of attention had been given to providing high quality education regarding RS with NFP nurses and supervisors. However, this tended to be at the outset of the core learning program, before participants had much experience to draw on. A number of respondents commented that ongoing learning and examples of RS practice (possibly in the form of videos) would be helpful.

It was noticeable that very few respondents highlighted the use of data reports to shape RS discussions. Educational materials to support this would therefore be helpful.

RECOMMENDATIONS

As a result of the findings in this project, the international team are proposing a number of recommendations to take forward the findings from this project. These are for both the International Team and country Clinical Leads:

For International Team

- Develop a *Guidance Document* for Clinical Leads, that incorporates the findings of this review and provides additional guidance for new and existing countries on implementation and use of the NFP Reflective Supervision framework.

- Review and *adjust the supporting text for CME #12* in line with the findings of this review
- Create a small working group of international clinical leads to review and develop *appropriate documentation* to support and guide reflective supervision in line with the new framework
- Establish a '*Community of practice'* on the International Website to develop RS quality improvement approaches, share education and develop additional CPD resources.

For Clinical Leads

- Review the contents of this report and guidance document.
- Participate in the Clinical Advisory Group discussion of the report findings (21 May 2019).
- Identify areas where their country's arrangements are not in line with the guidance document and new NFP RS framework and consider next steps for addressing these.
- Participate in the working group and/or community of practice that will be established by the international team.

APPENDIX A: Reflection and Supervision Models/Frameworks

Author	Summary of Model
Driscoll: Experiential Learning Cycle [78] [79]	Driscoll matched three questions to the stages of experiential learning cycle and adding trigger questions which can be used to promote the learning experience and reflect on what was learnt 1. What? (returning to the situation) 2. So what? (understanding the context) 3. Now what? (modifying future outcomes) • Key attributes of effective facilitators are: an ability to work, collaboratively, integrity, honesty, sensitivity, self-awareness, credibility, and a sense of humour
Gibbs: Reflective Cycle [80] [81]	Gibbs proposes a reflective cycle that starts with describing a practice event and then cycling through the following stages in consecutive order: 1. Description – Brief, concise, recollection of what happened 2. Feelings - Discuss your feelings and thoughts about the experience 3. Evaluation - What went well/didn't go well in the situation? 4. Analysis - Consider what might have helped or hindered the event 5. Conclusion – What you have learned from the experience; consider whether you could you have responded in a different way/what else could you have done? 6. Action plan - If situation arose again, what would you do? What do you need to know and do to improve/prepare for next time? ➢ This model is particularly useful for helping people learn from situations that they experience regularly, especially when these don't go well. ➢ Sometimes the stage of "Analysis" is included as part of "Conclusion", reducing the model to 5 stages
Gilkerson: Facilitating Attuned Interactions (FAN) [82] [83] [84] [85] [86]	FAN aims to build parenting capacity and self-efficacy by encouraging home visitors to focus on parents' concerns and needs. At the heart of FAN, is the practitioner's ability to maintain a "reflective posture" which is the ability to be fully present, monitor affect and engagement cues, offer interactions using the core processes that are attuned to the parent's readiness, and observe the parent's responses. "Attunement" is the theory of change guiding FAN. The "ARC of engagment" provides a structure to pace the home visit and give the prctitioner and parent time to refelct on their experince. FAN has 5 processes: Mindful Self-Regualtion, Empathetic Inquiory, Collaborative Exploration, Capacity Building, and Integration. Staff engage in a reflective learning process with their supervisor that mirrors the prociess that the NFP

	nurse and client engage in (parallel prociess).
Hawkins & Shohet: The Seven Eyed Model of Supervision [87] [88]	The power of this model comes from being able to view your work from seven different perspectives. This model facilitates the supervisee and supervisor to be curious and make sense of what is going on in both the relationship with the client and her unborn baby or infant, and the supervisory relationship itself, exploring: 1. The Supervisor system 2. The Supervisor interventions 3. The relationship between the Supervisor and her client 4. The Supervisor's own experience 5. The Parallel Process 6. The Supervisor's own self-reflections 7. The Wider Context (e.g. culture of the organization)
Kadushin: Model of Supervision [89] [90]	Proposes three discrete but interconnected functions of supervision: 1. Administrative – the promotion and maintenance of good standards of work/practice, co-ordination of practice with policies of the site/program administration, the assurance of an efficient and effective team 2. Educational – supporting the professional development of each team member in a manner that will facilitate her fully to actualize her full potential 3. Supportive – the maintenance of harmonious working relationships, the cultivation of "esprit de corps"/team spirit and commitment
Kolb: Experiential Learning Theory [91] [92]	Kolb's four stage model is a simple description of the learning cycle which shows how experience is translated through reflection on concepts, which could be guides for active experimentation and the choice of new experiences. 1. Concrete Experience: a new experience or situation is encountered, or a reinterpretation of existing experience 2. Reflective Observation of the New Experience: of particular importance are any inconsistencies between experience and understanding) 3. Abstract Conceptualization: reflection gives rise to a new idea, or a modification of an existing abstract concept the individual has learned from their experience 4. Active Experimentation: the learner applies their idea(s) to the world around them to see what happens ➢ The learning cycle can begin at any one of the four points and should be

<table>
<tr><td></td><td>approached as a continuous process</td></tr>
<tr><td>Morrison & Wonnacott: 4X4X4 Integrated Model of Supervision [93] [94]</td><td>The 4x4x4 supervision model brings together: four functions of supervision, four stakeholders in supervision, and four elements of the supervisory cycle. Supervision is not an add-on activity but rather one which is intimately linked with the quality of the service received and the degree to which the service has a positive impact on the lives of people who use services. This “supervision-outcome chain” process has seven factors linking the quality of supervision to eventual outcomes for people who use the services: role clarity, role security, empathy, assessment, partnership, planning, and coaching/intervention.
<table>
<tr><th>Four stakeholders in supervision</th><th>Four functions of supervision</th><th>Four elements of the supervisory cycle</th></tr>
<tr><td>People who use services</td><td>Management</td><td>Experience</td></tr>
<tr><td>Staff</td><td>Support</td><td>Reflection</td></tr>
<tr><td>The organisation</td><td>Development</td><td>Analysis</td></tr>
<tr><td>Partner organisations</td><td>Mediation</td><td>Action planning</td></tr>
</table></td></tr>
<tr><td>Proctor: Functions of Clinical Supervision Model [95] [96] [97] [98]</td><td>This model describes three components of supervision:
1. Normative (Accountability):
Supports staff to develop their ability and effectiveness in their clinical role, enhancing their performance for/within the organization/site. The aim is to support reflection on practice with an awareness of local policy and code of conduct.
2. Formative (Learning):
Enables staff to learn and continually develop their professional skills, fostering insightfulness through guided reflection. It focuses on the development of skills, knowledge, attitudes, and understanding.
3. Restorative (Support):
Explores how staff respond emotionally to the work of caring for others. It fosters resilience through nurturing supportive relationships that offer motivation/encouragement and that can be drawn upon in times of stress.</td></tr>
</table>

APPENDIX B: Attributes That Support the Development of a Reflective Supervisory Relationship [99]

Attributes	Message to supervisee
1. Safety	I will accept what you have to tell me. I will listen carefully and respond as I am able. I will set limits for you that are clear, firm and fair. I will be available if you need me.
2. Consistency	I will explain the work as I understand it and respond to you with care and concern. If something is not clear to me, I will ask you to tell me a little more.
3. Dependability	If we have scheduled a meeting, I will make every effort to be there when I said I would be there. I will try to let you know where you can find me or when I am going to be away.
4. Respect, Confidentiality	I will accept you and all that you tell me. I won't be judgmental. I will keep what you tell me between us and not share it with others without your permission.
5. Honesty	I will be open with you. I will let you know when I think things are going well for you and for the families you are working with. I will also let you know when I have concerns.

Adapted from: *Weatherston DJ, Barron C. (2009). What does a reflective supervisory relationship look like? In S. Heller S, Gilkerson L (Eds.), A practical guide to reflective supervision (pp. 63-82). Washington, DC: Zero to Three Press; p. 65*

APPENDIX C: Reflective Supervision Project Interview Guide – Clinical Leads and Key informants

Interviewer: _____ Date: _____

Interviewee: _____ Position: _____

Country: _____

For this project we are focusing on 1:1 Reflective Supervision including observed home visits. Any group supervision activities such as case conferences are out-of-scope. We would ask that you therefore focus your responses on the 1:1 aspects of Reflective Supervision.

Please carefully review the section describing CME #12 from the international guidance document (we have provided this to you as a separate handout) prior to your interview as this will help formulate your responses. We would ask that you have this document available during your interview to refer to specifically for question #13.

1. Please describe the model of NFP reflective supervision that you use in your country.

2. How does this compare to models of nursing supervision primarily used within your country?

3. From your perspective, what are the most important goals of reflective supervision in NFP?

4. What do you expect your nurses and supervisors to include within their 1:1 NFP supervision?

5. What impact do you believe reflective supervision has on the quality of the program and why?

6. How do you ensure that NFP supervisors understand the requirements and expectations of their role and the NFP program model?

7. What arrangements do you have in place for reflective supervision for your supervisors? [probe for how often this happens, and who does it]

8. What factors facilitate the provision of reflective supervision to NFP nurses?

9. What factors impede the provision of reflective supervision to NFP nurses?

10. What factors (if any) impede the ability of nurse supervisors to conduct observed home visits as required every 4 months?

11. How do you support and ensure that supervisors are skilled in conducting reflective supervision?

12. What are the impacts on reflective supervision when a nurse and supervisor do not have a close, trusting professional relationship –?

13. What challenges do you face (if any) meeting fidelity for Core Model Element #12?

14. How do you monitor the quality of supervision in your NFP program?

15. What has been the biggest challenge in implementing reflective supervision in the context of your country?

16. If you could make changes to the NFP model of supervision, what would you recommend and why?

17. Before we end today, are there any additional comments you would like to share with me?

APPENDIX D: Reflective Supervision Project - Questionnaire for NFP Supervisors

Country: _____ Date: _____

For this project we are focusing only on 1:1 Reflective Supervision including field supervision/observed home visits. Any group supervision activities such as case conferences, team meetings, and education/learning activities are out-of-scope. We would ask that you therefore focus your responses on the 1:1 aspects of Reflective Supervision. Please carefully review the section describing CME #12 from the international guidance document (we have provided this to you as a separate handout) prior to your interview as this will help formulate your responses.

1. What are the most rewarding aspects of engaging in a trusting relationship with your NFP nurses and participating in reflective supervision?

2. From your perspective, what are the most important goals of reflective supervision in NFP?

3. What factors facilitate the provision of reflective supervision to your NFP nurses?

4. What factors impede your provision of reflective supervision to your NFP nurses?

5. Which areas of your nurses' work do you expect them to reflect on within their supervision with you?

6. What impact do you believe reflective supervision has on the quality of your NFP program and why?

7. Do your nurses undertake any other supervision (with you or with others) in addition to the reflective supervision you provide? ❑ No ❑ Yes →Please describe using the table below:

Supervision undertaken	Person providing the supervision

8. What arrangements are in place for you (as an NFP supervisor) to receive reflective supervision?

   - How often does this happen?
   - Who does it?
   - What is the quality of this RS?
   - Who else do you reflect with?

9. What support/education have you received to ensure that you are skilled in conducting reflective supervision?

10. If you were observing an individual undertaking NFP supervision, what key things would you look for to identify that this is being conducted in a safe, skilled and reflective way?

11. What do you feel are the benefits of observed home visits?

12. What do you feel are the challenges of observed home visits and how have you overcome these?

13. If you could make changes to the NFP model of supervision, what would you recommend and why?

14. Are there any additional comments you would like to share with us?

APPENDIX E: Reflective Supervision Project - Questionnaire for NFP Nurses

Country: _____ Date: _____

For this project we are focusing only on 1:1 Reflective Supervision including field supervision/observed home visits. Any group supervision activities such as case conferences, team meetings, and education/learning activities are out-of-scope. We would ask that you therefore focus your responses on the 1:1 aspects of Reflective Supervision. Please carefully review the section describing CME #12 from the international guidance document (we have provided this to you as a separate handout) prior to your interview as this will help formulate your responses.

18. What are the most rewarding aspects of engaging in a trusting relationship with your NFP supervisor and participating in reflective supervision?

19. From your perspective, what are the most important goals of reflective supervision in NFP?

20. What factors facilitate the provision of reflective supervision with your NFP supervisor?

21. What factors impede the provision of reflective supervision with your NFP supervisor?

22. Which areas of your work do you reflect on within your reflective supervision with your NFP supervisor?

23. What impact do you believe reflective supervision has on the quality of your NFP program and why?

24. Do you receive/seek any other supervision in addition to the reflective supervision provided by your NFP supervisor? ❑ No ❑ Yes →Please describe using the table below:

Supervision received/sought	Person providing the supervision

25. What support/education have you received to ensure that you understand the purpose of NFP reflective supervision?

26. If you were observing an individual providing NFP supervision, what key things would you look for to identify that this is being conducted in a safe, skilled and reflective way?

27. What do you feel are the benefits of observed home visits?

28. What do you feel are the challenges of observed home visits and how have you and your supervisor overcome these?

29. If you could make changes to the NFP model of supervision, what would you recommend and why?

30. Are there any additional comments you would like to share with us?

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