Disquiet in the Development of Clinical Supervision for Professional Development in Nursing Practice:

A literature Review

555 NURS

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By

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ABSTRACT

Nursing literature reflects that nurses have been exploring and experiencing the process of clinical supervision for well over a decade. Nurses in the United States (U.S.), United Kingdom (U.K.), Scandinavia, and Australasia have written much over the past fifteen years. While nurses grapple with what clinical supervision is within nursing development and disquiet continues to emerge in the literature. While the process of clinical supervision has been borrowed from the fields of psychotherapy, social work, counselling and mental health nursing, resulting in different forms of implementation, a considerable body of data has been developed illustrating nurses' experience of developing the process within their own varied areas of practice. This literature review will expand on themes that surround this disquiet. These centre on continued confusion and lack of clear definition; whether psychotherapy is implemented under the guise of clinical supervision, who uses it, and the dearth of empirical evaluation of its effectiveness. The lack of significant empirical evidence of its ability to assist practitioners to deliver improved patient/client care continues despite claims of improved professional and personal development, therapeutic relationship, and occupational stress management. These claims come from both supervisees and supervisors. The manner in which clinical supervision is portrayed in nursing in that it is frequently referred to as a support system, rather than one of learning a complex set of

communication skills is also highlighted. The continued debate on what model(s) best suit nurses, or whether line management should provide clinical supervision as a means to ensure quality standards and control over nursing practice and optimal patient care is discussed. Whether nursing should stop borrowing from other fields and develop their own model(s) is also a question being raised. Two emerging stances focus on a process that is practice-based as identified by senior staff and management, or one that continues along the lines of what psychotherapy has developed with practitioner-identified developmental needs. These issues raise many questions for further development in nursing, one being are nurses developed enough in their self-awareness to understand what they are to adopt into their practice? Authentic voices from those nurses experienced in the practice of providing and receiving clinical supervision, are shaping therapeutic practice for nurses in the future, and continue to sharpen the debate. Some reference to unpublished data and local practice in the Wellington area, New Zealand, have been included as a stimulus for further incorporation of clinical supervision in local practice development.

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INTRODUCTION

The background to this research stems from the author's experience, training and implementation of clinical supervision in a hospice setting. Interest in, and experience of clinical supervision by New Zealand nurses, has been developing since around the mid 1980's. This development parallels the interest of nurses in other countries.

Nurses recognising the need for a safer, more professional self-reflective approach to their nursing practice, is at the heart of clinical supervision developing a higher profile in the nursing profession today (Butterworth and Faugier, 1992; UKCC, 1996; and Ashmore and Carver, 2000). A parallel in the development of writing in this field, for nursing, mirrors the development of nursing practice from a hierarchical, bureaucratic, task-oriented mode, to one of developing further independence, accountability and responsibility.

However, not much has changed in our understanding of processes and practices of clinical supervision as demonstrated in published nursing literature over the last 10 years (van Ooijen, 2000). The subject continues to remain ambiguous and ill defined in nursing. Nurses have published scores of articles in the past decade revealing nurses' understanding and application of clinical supervision, but few authors describe the nitty-gritty of what is involved. This lack of clarity risks further contribution to the ambiguity reflected in the variety and varying development of the differing forms that nurses are implementing. Related processes such as preceptoring, mentoring and reflective practice appear to be incorporated into the process of clinical supervision by some authors (Johns, 1996; UKCC, 1996; Fowler and Chevannes, 1998; and Graham, Waight and Scammell, 1998), who appear to continue to confuse the specifics of the process. Neither is there very good empirical evidence as to its effectiveness.

However, nursing interest and exploration of the above processes are revealing something of the nature of clinical supervision as it is experienced and

understood by nurses in their varying work practices. Vigorous discussion and debate on how it might be defined (Sloan, 1998; & Yegdich, 1999), practiced, (Farrington, 1995; Fowler, 1996; Bulmer, 1997; Butterworth, 1997; Jones, 1997; Nicklin, 1997; Bowles & Young, 1999; and Yegdich, 1999), remains lively in the nursing literature from North America, Scandinavia, particularly the United Kingdom, and more recently, from Australia.

The intensity of interest the nursing profession has, in various aspects of clinical supervision, is reflected in nurses' writing. These aspects range from: definitions and naming of clinical supervision; models of practice; the benefits to the practitioner; education of supervisees and supervisors; ethics and documentation; what nurses want in a supervisor; implementation in nurses' work environments; measurement of its effectiveness; to which nurses are using it. Repeatedly, the key concerns being raised focus on what is actually practiced in the name of clinical supervision, what models of clinical supervision are incorporated into practice, and who is controlling the power base with emerging management control over practice. Yegdich (1998) refers to how it ought not be practiced, with particular reference to the process not being therapy for nurses (Yegdich 1999), nor risking loosing sight of the nurse-patient relationship (Yegdich 1998). All of the above reflect the complexity of nurses' experience of clinical supervision, as well as the development of nursing research in this field. Of concern, after all this "labour", is the lack of clarity in the literature. Is this reflecting nurses' difficulty in clearly articulating nursing practice?

Particular challenge is coming more directly from practitioners in the mental health area, (Morris, 1995; Jones, 1997; Scanlon & Weir, 1997; and Yegdich, 1998, 1999, 2000), some of who are also practicing psychotherapists. They are either challenging nurse colleagues who practice psychotherapy in the "guise" of clinical supervision (Yegdich, 1998), or illuminating the incorporation of psychodynamic techniques in their clinical supervision practice (Jones, 1997; 1997a; 1997b; 1997c; 1998; 1999; and Evans & Franks, 1997). Power imbalance of the application and practice of clinical supervision in nursing, when management is involved in giving this practice, is being questioned as a form of

management control in the bid to adhere to quality measures (Burrow, 1995). Management do have a stake in the effectiveness of clinical practice for patient care, and in revealing the effectiveness of nursing practice if they are purchasing clinical supervision. Whether managerial supervision is justified for quality assurance, or accepted by nurses, will have quite a bearing on how clinical supervision is practiced by nurses in the future.

Of special interest are those review articles that focus on the themes of: workplace organisation of clinical supervision; characteristics of a good supervisor; effectiveness of group supervision; and those evaluative studies on the experiences of nurses receiving and delivering clinical supervision. Appearing more frequently are articles where practitioners are revealing their practice with case studies (Johns, 1996; Jones, 1997c; 1997d; 1997e;1998;1999). Responding to the continued lack of clarity, and in an attempt to assist nurses to better understand the process of clinical supervision, van Ooijen, (2000) has written a book to illuminate her practice and process from a more practical perspective. It is also an excellent source of information about the historical development and origins of the various models of clinical supervision. Her book is a good example of empowering nurses to better understand the process, as well as naming and claiming specific nursing involvement. Her claim that every occupation that is people-oriented necessitating good personal skills will find that clinical supervision helps people function to the best of their ability. She also makes the point that nursing's "unique" culture has been traditionally defensive and not conducive to nurses admitting feeling stressed or distressed about their work. The historical influences in nursing of servitude, the military, and latterly medical control, have added to this defence. Currently, we are experiencing further involvement from management.

AIMS OF THE RESEARCH:

Although editorials and short articles have been studied, the primary use of in-depth articles with substantial references have been utilised to aim for clarity of analysis. Because of a dearth of published local literature, an informal search for unpublished literature from the Wellington area in New Zealand has been

attempted. This informal New Zealand scene demonstrates some similar discussion and parallel development but without a national directive such as that of the United Kingdom from the UKCC, nor are there any published research results.

This literature review will attempt to:

1. provide an overview of the nature of the developing debate with emphasis on review articles on clinical supervision in nursing
2. provide an overview of clinical supervision implementation. Insights from the author's practice and experience are included in Appendix 1, and a brief description of known nursing initiatives in the Wellington area is included in Appendix 11.
3. provide an overview of nurses' experience of clinical supervision
4. discuss the disquiet in the nursing literature, with reference to the development of the practice of clinical supervision, and relate this to the author's experience in a hospice/palliative care setting in New Zealand (this experience is included in an appendix as subjective data was not the immediate scope of this research method).
5. offer recommendations to assist the further creation of guidelines for implementing clinical supervision into nursing practice in New Zealand.

The value of this study is as a comprehensive resource from which further discussion and study can result, for example, the formulation of guidelines for developing the practice, implementation, and scope of clinical supervision for nurses in New Zealand.

LIMITATIONS OF THE STUDY

The lack of published New Zealand nursing data on the practice of clinical supervision for nurses by nurses, or on the implementation and evaluation of the practice into nursing training and practice, continues to obscure those achievements already undertaken.

The breadth of this literature review is in relation to clearer definitions of clinical supervision that are similar to that of the author's understanding and use of clinical supervision in practice. Some reference is made to the better-designed evidence of nurses' experience of clinical supervision.

LACK OF CLARITY

One of the problems of, and concerns for the delivery of clinical supervision in nursing practice, is that there are very different meanings, practices and realities used to describe the process. Many authors do not attempt to succinctly define it. The experience of clinical supervision itself is a very subjective one. There is also difficulty defining a dynamic interactive process that has differing interpretations and models of delivery. Because there is a dearth of empirical evidence in the literature clearly demonstrating its effectiveness in advancing nursing practice and improving patient care, but with frequent claims as to its effectiveness, (McKee, 1995; Butterworth, 1997; Brocklehurst, 1997; & Pugh, 1998), the actual nature of it can become lost. If an action and a consequence cannot be described, how can empirical research be carried out? This lack of evidence is also true for the fields of counselling and social work where it originated in the 1920's. However, there are real difficulties in being specific because the supervisory relationship is bound by confidentiality. This may have created a certain mystique and confusion about what it actually is, and what it achieves. Claims of its effectiveness risk suggesting that nursing might be expecting clinical supervision to be a panacea for all that is not right in the world of nursing. Emerging research might be indicating benefits to nurses' relationships with patients, and themselves. This will be discussed in the section on evaluation.

The use of reflective practice in nursing has been developed and incorporated into nursing practice at both under-graduate and graduate levels. These processes also have unclear definition and demonstrated value as to how they actually affect practice and patient care. Reflective practice, guided reflection, mentoring and group supervision are concepts also being referred to in the

literature on clinical supervision, inferring, in some cases, that they are one and the same thing. Fowler & Chevanne (1998) make the point that in clinical supervision sessions there is considerable congruence in the use of reflective practice but it ought not be an integral part of all forms of clinical supervision. A common theme in the literature of the importance of the interplay between clinical supervision and reflective practice is very strong, and an integral part of the process. It could be that clinical supervision is the formal process, and reflective practice is the enabling process as Fowler & Chevanne (1998) suggest. Reflective practice, according to Benner, cited in Fowler & Chevanne (1998 p 381), occurs more in the individual's progress in terms of her "expert". Fowler & Chevanne (1998) caution on reflective practice techniques being inappropriate in clinical supervision if reflective practice is not a preferred or experienced process. Rather, the model of application of clinical supervision ought to respond to the supervisee's needs, which is its strength.

Ostermann & Kottkamp (1993 p 19) define reflective practice as:

> *"A challenging, demanding, and often trying process that is most successful as a collaborative effort. ... A means by which practitioners can develop a greater level of self-awareness about the nature and impact of their performance, an awareness that creates opportunities for professional growth and development."*

Their particular focus on behavioural change due to awareness about one's own behaviour, and with the intent of the instructor as facilitator, learner as agent and practitioner as action-researcher, demonstrates significant elements of clinical supervision. Within the reflective practice model, based on the work of Schon (1987), providing feedback and interpretation of information takes place in an open and equitable discussion among all relevant parties. Therefore, if the clinical supervisory relationship is bound by confidentiality, can it be said that it is reflective practice? What then is "group supervision"? Could group supervision be group reflective practice? These differences are not clarified by many authors.

The Concise Oxford Dictionary (1991) defines a mentor as *"an experienced and trusted adviser"* from the Greek:- adviser of the young. Palmer et al (1996), define a mentor as:

> *"An experienced, competent practitioner in a clinical area who will work with (the student) on a one-to-one, day-to-day basis".*

Mant (1997) makes the interesting comment that in organizations which have "downsized", managerial vacuums have occurred. In the modern "lean" organization, a lot of people are under-managed. Because the span of control has widened they have more subordinates to manage, and may be at a younger age than formerly. Such an employee is bound to need a coach or mentor. In the past, organizations had a parent-like relationship between boss and employee, but now trust flows from personal understanding, and continuity lies with an outsider. This idea relates to nursing in that many nurses are indeed being challenged to provide comprehensive, specialist care, but mentoring in this sense does not equate with clinical supervision.

This raises question as to whether mentoring is more appropriate for managers, and clinical supervision is more appropriate for the clinician or practitioner.

DEFINITIONS OF CLINICAL SUPERVISION

Definitions of clinical supervision are few and far between in the nursing literature. Some examples of supervisee-led clinical supervision that are triadic in form, i.e. working within boundaries that define patient, supervisor, and the supervisee, Yegdich (1998) are specifically referred to. These latter definitions reflect the author's experience of receiving clinical supervision, as well as that of some authors who seek to clarify their definitions and practice. Therefore, this section refers to the process of a formal 1:1 partnership that seeks to make conscious the often unconscious feelings and decision-making processes of the supervisee in the patient-nurse, nurse-colleague relationship. Support, skill enhancement, education, and developing professional behaviour are the main intent for the process defined. Discussion of the impressions gained from how clinical supervision is described will also be covered.

Irvine (1998) states that "supervision is not a panacea, but rather one means of providing support and a place in which to grow". She further states (1998) that the umbrella term clinical supervision is used to describe a formal process used for educational, supportive and quality control purposes, and not to be confused with management or dual role supervision (where manager also provides clinical supervision), or overseeing nursing students or unqualified staff. Increasingly, the term *professional supervision* is being used to distinguish the formal process that aims at professional development.

The most frequently quoted definition of clinical supervision is that of Butterworth (1992, pp 3-17):

> *[Clinical supervision is] "an exchange between practicing professionals to enable the development of professional skills".*

These words could describe any nursing collegial contact, therefore is not helpful in increasing one's understanding of the process.

The UKCC position statement (1996), in its key statement number 2 p. 4 defines clinical supervision as a:

> *"...practice-focussed professional relationship involving a practitioner reflecting on practice guided by a skilled supervisor".*

In this definition we begin to see the reference to special training for the clinical supervisor, but this statement does not clarify sufficiently. However, seen in the context of the referred to document as a whole, clearer parameters for the process are set out to encompass aims, training and implementation. It is interesting to note that in an evaluative study on clinical supervision by Butterworth et al (1997) no clear definition is given though numerous references are made to other authors. In her 1995 article, Farkas-Cameron, p. 36, views clinical supervision as:

> "*...a process of engaging in a potentially supportive, trusting, and respectful relationship with a colleague to advance one's level of clinical practice...the gateway to a self-actualising process that assists the nurse to perform his or her fullest potential by fostering the growth of skill development...[clinical supervision] can be therapeutic as feelings and concerns are ventilated as they relate to the educational process of learning within patient-nurse relationship*".

Clinical supervision in part fulfils nurses' (and counsellors', social workers' etc) obligation of being accountable to the public, and ensuring patient and clinician safety, particularly around intimate interactions with no witnesses. Peplau (1991 cited in Farkas-Cameron, 1995, p. 32.) elaborated further that:

> *"A nurse cannot pay attention to cues in the situation when her own needs are uppermost and require attention to the situation. Her observations are unwittingly focussed upon the*

way in which her unrecognised needs are being met by the patient....Until the actual needs of the nurse are met or identified so that she is aware of what they are and how they function as barriers to the patient's goals, she does not have control [over safe practice]."

Although both these authors are in the mental health field, and their supervisees are working with people in therapy, the issue of nurses not being willing to take up clinical supervision could be perpetuating professional blindness if nurses ignore their personal impact on nurse-patient relationships. An example of the power of a nurse's own culture and ways of doing things, and their impact on the people they work with is demonstrated in the concept of Cultural Safety as developed by Ramsden (2000). Ramsden demonstrates that if one is not open to one's own culture then we may not be open to that of another. Nurses may not always be aware of their impact on patients. Clinical supervision is a method of assisting behaviour to become more conscious. Encouraging nurses' professional development is inherent in Peplau and Farkas-Cameron's work. In the search for a supervisory relationship within which they are truly able to explore their practice, particularly in terms of their development of their therapeutic relationship with patients, some nurses have gone outside of their workplaces to secure this. The value of clinical supervision is that it can be a continuous developmental activity compared with discrete teaching.

Consedine (1995) writes that a way forward for nurses, especially those who have not had a mental health or psychotherapy background, is "supervision for role development". In his many years as a mental health nurse, recipient, trainer and provider of clinical supervision in New Zealand, Consedine developed a training programme that aims to assist nurses to provide clinical supervision for nurses by nurses using Moreno's role theory as a basis. Moreno's work, influenced by psychodrama, defines "role" as:

" the functioning form the individual assumes in the specific moment he reacts to a specific situation in which other persons or objects are involved"

(Consedine, 1995, cited in Moreno, 1946 p 4).

If role represents a way of being in the world, then it can be defined in terms of what a person is doing, as well as the quality of that action. It also clarifies that clinical supervision is not line management. The following diagram sets out the two streams of clinical supervision.

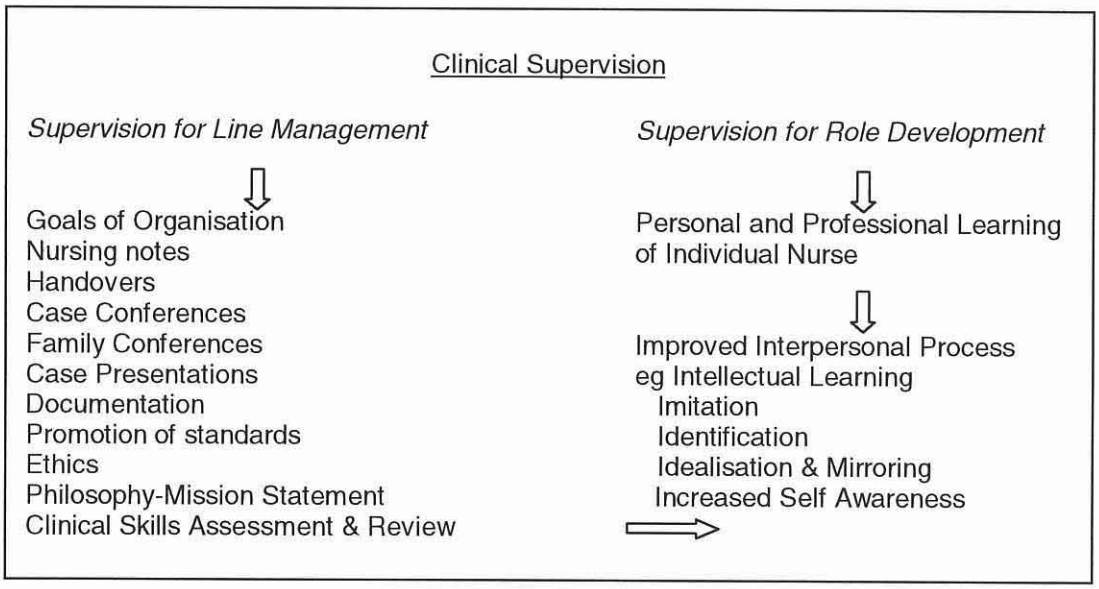

Figure 1. Two Streams of Clinical Supervision (adapted from Consedine, 1995, unpublished).

The distinction between management supervision and clinical or professional supervision is outlined in figure 1. Personal development using in depth reflection and interaction with a supervisor is not appropriate for line management supervision, though this is also important for guaranteeing competency. Consedine (1995) clarifies the real purpose of clinical supervision as role expansion" so that more roles and more therapeutic responses can be mobilised with the patient. A common role in nursing, or one we can easily slip into is the over-developed one of "all-knowing Ms/Mr Fixit". Another example of how

supervision for role development can stimulate role development is to challenge a role nurses readily warm up to of "warm nurturing reassurer", and assist them to move more to one of 'naive inquirer" (Consedine, 1995). A role also involves thinking and acting as well as words that are spoken. If clinical supervision or professional supervision was seen as a sophisticated form of skills training, rather than one of support, it would remove the notions of "not coping" and "snoopervision" that seem to stand in the way of more nurses actively seeking clinical supervision. Rather than the idea of "being done to", the process could be seen as one of empowerment and development, and "doing for "oneself.

Supervisors must be well trained and experienced in order to build on what the supervisee already has profoundly integrated into their personality, focussing with this other person on his or her inner experience. The idea of the "voice from within", as the catalyst for a nurse's professional development in dealing with hugely intimate and challenging relationships, seems a healthy place to begin.

Consedine (1995) defines clinical supervison as :

> *"a process where the clinical practice of the nurse is brought under scrutiny and by using this activity as a starting point in the process of resolving their own inner conflict and in developing their ability to interact with their clients in ways that are optimally therapeutic...to more fully appreciate the meaning of her experience, to develop her abilities, to maintain standards of practice and to provide a more therapeutic service to her client...[clinical supervision] involves the resolution of inner conflict and the development of the integration of new skills ...for professional role development of our own ways of being in the world in relationship with our patients is the ultimate purpose of supervision."*

And the functions are laid out clearly thus:

> *"The functions of supervision are for the transmission of learnable techniques and attitudes...a supportive function for*

difficulties that are inherent in or imposed on the therapeutic relationship...an analytic function to increase the awareness of how he or she affects the therapeutic relationship and outcome".

(Mellow, 1968 cited in Consedine 1995, unpublished).

Here is a model of teaching and practice, which focuses on the therapeutic interaction and communication of the self, reaching the part of us which is not always readily conscious.

Burrow (1995) in his question on whether clinical supervision is clinical development or management control, refers to further definitions, which include:

"...an intensive, interpersonally focussed, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person"

(Loganbill et al, 1982)

and

" a quintessential interpersonal interaction (whereby) the supervisor, meets with another, the supervisee, in an effort to make the latter more effective in helping people" (Hess, 1980)

and

"...a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations...expansion of the scope of practice...encouraging self-assessment and reflective practice"

(Department of Health (UK) 1993, A Vision for the Future, cited in Sloan, 1999, p 524).

These last three definitions can give the impression that clinical supervision is more of a benign, supportive role that improves therapeutic skills, transmits knowledge and facilitates reflection on activity. However, they do not capture the essence of experience and skill enhancement that develops the practitioner and ensures safe and quality patient care. Nursing has already devised many methods for the delivery of safe clinical physical and emotional care. The setting of standards and competencies (both nationally and internationally), evaluation by appraisal and worksite supervision, preceptoring and mentoring, line or performance management, audit and research are aimed at supervising the hands-on care. Sloan (1999) makes the point that the expectations of clinical supervision are far–reaching. Why then has nursing adopted this wide interpretation of its meaning? How can the concept possibly be measured when there are so many variables? What becomes of nurses' therapeutic effect on their patient relationships if clinical supervision is taught at undergraduate level, then hoping that this qualification will last for life? There are serious issues here if clinical supervision is already in the guise of other processes, because much finance, learning and angst has gone into implementing varying forms of the process without a lot of empirical evidence to show much benefit for it (Sloan (1999). For nurses to have clinical supervision offered as a tool for professional development clarity is urgent.

A model used by the Plunket Society (early childhood health service) in New Zealand has some additions to the above definitions. From a workshop conducted by the author and Polaschek (1999 unpublished) for a Nursing Masters (Applied) school the following definition of clinical supervision was used:

> *"[Clinical supervision] is a formalised structured time, with a primary focus for one person to talk and the other to listen, support and challenge...It uses catalytic questions-ones that draw out the person's narrative...it is formalised, structured and regular...it is a process of sustained review of one's practice... it is about promoting professional development and safe practice."*

This service names the process 'professional supervision' and provides it for all staff for the following reasons:

> *"It encourages best practice, self awareness and reflection ...It develops problem-solving skills, and enhances learning from our own experience...It addresses the power imbalance in the professional client/patient relationship...It challenges assumptions and values...It assists in maintaining personal integrity and self respect".*
>
> *(Polascheck, unpublished, 1999).*

Since 1993, the author's workplace has made clinical supervision available for hospice staff. The process is named "professional supervision" and is included in the "Supervision for Professional Development" policy which includes staff support mechanisms other than clinical supervision, and clarifies such terms as staff appraisal, "buddying", debriefing, and peer support (the policy currently refers to "preceptor" instead of "buddy"). Two forms of supervision are outlined and offered: feedback on their day to day performance including performance standards and formal appraisals, plus supervision for professional development (individual and group). The process for accessing clinical supervision and the parameters for contract setting are clearly set out in the policy. Supervision for Professional Development is described thus:

> *"The main focus of this supervision is what is happening between the health professional and her/his patients or the counsellor/therapist and her/his clients. It is a supportive and educative process in which staff have structured paid time to reflect on practice, develop skills and knowledge and to consider educational and training needs under the guidance of a trained supervisor. The supervisor who should have experience or be trained in the supervision process may need to come from outside the hospice to ensure confidentiality".*

Morris (1995) refers to Phillips et al's discussion of learning events that is particularly helpful in discerning between the two fundamentally different notions (managerial or therapeutic) of clinical supervision. Cited in Morris (1995):

> *"Professional action involves learning from experiences, assessing courses of action and performance, and making judgements about outcomes. It is an ongoing, "natural" part of nursing. Performance, on the other hand, involves doing something to demonstrate ability to someone else".*

Decision-making is at the heart of health care and often it is a hidden process. Therefore, clinical supervision can assist the practitioner to see their own decision-making process more consciously.

Farrington (1995) rightly makes the observation that clinical supervision as a practice is difficult to tie down by definition. Irvine (1998) approaches the issue of definitions by focussing on terminology, describing models and processes of clinical supervision, and illuminates the concept well by doing this. Farrington (1995) also notes that clinical supervision is being associated with management supervision at one end of the continuum, and an elitist practice of practitioners far removed from the "real" world at the other. He makes reference to the "haves" and the "have nots" in that provision of clinical supervision is not offered to all nurses. If agreement on definition and supply cannot be managed, clinical supervision could end up being a divisive wedge, rather than being a unifying strategy. The risk then is that the process can become an irritant rather than an enjoyable, energising, and achieving one. This could be particularly so for managers who have to budget for it.

WHICH NURSES HAVE CLINICAL SUPERVISION?

It is interesting to note that not all the nursing literature written on clinical supervision has been by nurse leaders and managers. The contribution to the body of knowledge is emerging from a wide variety of practitioners, although much is descriptive rather than being research-based.

Much has been written by mental health nurses. Faugier (1994) refers to the 1994 review of mental health nursing in the UK, and how clinical supervision had found its way into the vocabulary of mental health nursing, without having any significant impact on practice. Its meaning has also been fraught with misunderstandings from the distinction between managerial supervision, lower management activity with a group, a simple method of supporting staff and preventing burnout, to an informal arrangement between peers. More progressive units developed clinical supervision outside of line management, but it was still seen as reserved for the master practitioner. Her concerns range from clinical supervision not being available for all mental health nurses, not all supervisors having the necessary skills to perform it, and neither have benefits to practice been proved. Reflective practice is being confused with clinical supervision, and Faugier (1994) claims that due to the reality of the "coal face" for practitioners working with emotional distress, disease, death, loss and confusion, few nurses have a stronger claim on support from clinical supervision than mental health nurses. This concept indicates that that mental health nurses have more need of clinical supervision than other nurses, which is unhelpful. More importantly, they may have considerably more experience of clinical supervision than most other nurses, and so are in a good position to encourage and support other nurses to take it up.

Ashmore and Carver (2000) six years later continue to refer to the advocated introduction of clinical supervision, as a result of the 1994 UK mental health nursing review. They demonstrate concern at the lack of guidelines for implementation. They refer to an educational initiative where undergraduate

mental health nurses were introduced to the concepts of clinical supervision in a group setting. Enhancement of the practitioner was the aim, and results demonstrated positive effects noted by the students that matched those perceived benefits noted by experienced practitioners. This study is one of the few studies outlining the benefits of group supervision. However, no definition of clinical supervision was given, which considerably devalues the study. It would also assist in the understanding of the difference between group and individual clinical supervision.

Brocklehurst (1997) refers to the value of clinical supervision for nurses working in nursing homes in the UK. Within an environment of rapid change, variable support and training, and working with skilled and unskilled staff clinical supervision is seen as a valuable tool for staff development. In complying with the UKCC directive that all nurses receive clinical supervision, he advocates that these nurses also are worthy of receiving this form of professional development.

Rodriguez and Goorapah (1998) comment on clinical supervision being considered in nurse education. They are cautious of implementation on the grounds that the nurse teacher role focuses on: academic rather than clinical issues; cost; and which model would be appropriate. They point out that the role of higher education needs to be established, and further benefits demonstrated, before clinical supervision can be seen as an opportunity, rather than a threat. The author would not agree with this caution. Clinical supervision is about any professional practice, and what is more relevant to clinical practice than teachers of nurses. Anecdotal evidence from New Zealand would indicate that clinical supervision is incorporated into some post-graduate studies of specialty nursing, for example mental health, child and family health, critical care, and cancer/palliative care course outlines. Nurse educators do use clinical supervision either as individual or group practice. They have recognised that issues of their own teaching practice need supervision. Education practice as described by Schon (1987) and Ostermann and Kottkamp (1993) indicates the need for regular peer and self-assessment, and in the author's experience, this can be taken one step further to include the practice of clinical supervision.

Lewis (1998) attempts to relate de Bono's "six thinking hats" process to the practice of clinical supervision in terms of nurse lecturer practice. This is a useful attempt to find what is already common in some nurse lecturers practice, and as an attempt to offer a model by which clinical supervision may be implemented. However, this author does confuse skills of reflective practice and does not clearly differentiate those of clinical supervision.

Practice nurses, whose work is often carried out in professional isolation in the UK, were at a distinct disadvantage compared to their colleagues in the national health system being employed by General Medical Practitioners. Farquarson et al (1998) refer to a pilot scheme for practice nurses in Tayside (UK) that provided workshops to improve practice nurses' understanding of clinical supervision in preparation for the extension of the pilot to provide clinical supervision. In the Wellington area at least one medical practice has monthly individual clinical supervision for nurses, paid for by the employer, and provided by external, trained clinical supervisors.

Nurse specialists in the UK are another group of nurses who are often called on to provide clinical supervision. Although this group of nurses have often had some training in counselling techniques, they may not have the skills nor the energy to provide clinical supervision for colleagues. The expectation that specialist nurses will provide clinical supervision for their colleagues places an extra burden on them. Because these nurses use counselling skills it is arguable that they receive clinical supervision training like their counselling colleagues. A scheme is described whereby stoma nurses have an independent consultative service to support them. This independent scheme is under trial and is carried out by experienced supervisors, not necessarily in the practice of stoma care. Again, no clear description of definition or method was described. Findings indicate that nurses' feelings of wellbeing have been enhanced, but no formal evaluation has yet been carried out.

A developing body of knowledge is accumulating on the value of clinical supervision to hospice and palliative care nurses. As already mentioned, some nurse psychotherapists have attempted to illuminate their practice of clinical supervision. Jones (1997c & 1997e) indicates the importance of the therapeutic relationship in palliative care. He proposes that engagement with a dying person presents the worker with *"parallel struggles manifesting in elementary feelings which require discernment"* (1997e). The complexity of feelings defies explication, and frequently, conversational therapies have a major contribution to offer. In developing competent and effective practice in working with death, the hopeless nature of the diagnosis, and the nature of unconscious connections, clinical supervision can aid nurses to understand their feelings and their "professional mourning", manage the witnessing of the reality of death, and assist developing their professional practice and communication skills.

Jones (1997c) outlines that the role of the palliative care nurse entails closeness to others through responsibilities concerning empowerment, advocacy, health education, and caring. The role is concerned with helping families and colleagues endure the often intolerable feelings, and in surviving suffering. Significant communication with others is required as is discrimination between personal feelings and those aroused through sustained communication with others. The notion that the need for all to release unexpected deep fears associated with serious illness and impending death. (Moyers 1993 cited in Jones 1997c), likens palliative care work to a "bonding between strangers' whose experience is so "interior" that attempts to understand merely alter the very process that we are trying to grasp. Jones states that it is through the supervisory relationship that we can examine our own unspoken messages in our relationship with dying patients. For example, how do we communicate our response and feelings when we work with a patient who has a foul smelling wound? or when they remind us of someone we have lost who is close to us? How do we manage this over and over again?

Jones (1997c) attempts to alert us to how clinical supervision can assist us to manage our own strong feelings that can, if not identified, be redirected into other

affiliations inappropriately. Focussing appropriately, and encouraging healthy and supportive healing professional alliances are also potential benefits.

Studies by Booth (1995), and McKee (1995) indicate that hospices in the UK are involved with implementing and evaluating clinical supervision. Booth (1995) indicates that the nurse's direct supervisor was the most significant figure in supporting them. Large group meetings and friends and family were identified as being unhelpful. However, it was practical rather than emotional support that was most useful, and the supervisor was not identified as providing clinical supervision. McKee's (1995) study of staff support in hospice showed that the unidentified emotional methods of support were not valuable to many staff. Both these studies were disappointing in that clinical supervision was not clearly described, identified, or as being of benefit.

In the Wellington area, hospice services offer a variety of forms of staff support. Individual and group supervision are available, as are reflective practice sessions, debriefings and reflective practice written work. Evaluation (Robertson, 1994; Stroh, 1999, unpublished) indicates value by nurses identifying improved stress management, support over the difficult times, and problem solving with difficult patient experiences and collegial relationships. However, the proportion of nurses to other disciplines who take up clinical supervision is markedly less (as at 1999). Nurses who are most likely to use it are either working in autonomous or leadership positions, or have some understanding of mental health and counselling practice. Further education and encouragement is required for nurses to be more accepting of clinical supervision and its value.

Dwan (2000), reports on an alliance between a nurse and a management coach who were discussing "regular protected time for facilitated, in-depth reflection on clinical practice", referring to clinical supervision. The nurse had found difficulty with group peer reflection, often based on a number of assumptions that are not all usually met, and realised she needed more time to reflect. This could not be done satisfactorily in a group setting over one hour. A nurse referring to an incident which left her unconfident and jittery for months identified what she

needed was more than a "helping hand". Farmer (2000) reports on her experiences of clinical supervision in New Zealand as a diabetes nurse educator and relates the contractual nature of the supervisory relationship. An attempt is made to define the practice referred to. Both authors note the need for a specially trained clinical supervisor as it is in itself specialist practice. This article, which refers to Irvine (1998), demonstrates the beginning of published literature on clinical supervision in New Zealand.

IMPLEMENTATION OF CLINICAL SUPERVISION IN THE WORKPLACE

The implementation of clinical supervision in nursing practice has been implemented and described variously. Begat et al's (1997) evaluative study describes nurses' views of the effects of supervision on nursing care after it had been implemented into a medical ward. The nurses had taken part in an education and experiential programme of clinical supervision. Unfortunately, the author did not include details of the actual implementation even though "implementation " was used in the title of the article.

A review article by Fowler (1996), details the organisation of clinical supervision in the nursing profession. There appears to be little structure on how this subject is organised within published literature. It seems that little effort has gone into structure for practice. Clinical supervision has been developed, according to Fowler (1997), in the form of direct clinical supervision, mentorship or preceptorship. The term mentor implies inspiring, investing and supporting, as well as a relationship lasting several years according to the meaning attributed to it from the business world (Donovan 1990 cited in Fowler, 1997). The term supervisor stems from the English National Board (ENB) (1993) document (cited in Proctor, 1997) where pre and post-registration students are assigned a clinically based supervisor. The role of the supervisor is to ensure that relevant experience is provided, and that their practice is to a safe standard. This relationship is hierarchical in that it is one between a qualified and a non-qualified professional, and therefore, may not qualify as clinical supervision in the therapeutic sense, though the terminology is similar. Anecdotal evidence of post-graduate student induction into the process of clinical supervision is somewhat removed from this hierarchy in that they already have extensive practice knowledge. Again, there is a disappointing lack of specifics as to what form of clinical supervision is being referred to, and the type of student.

The term preceptor in nursing means a clinical guide and teacher who assists a nurse or a senior nursing student new to an area over a short period of time. This

does not qualify as clinical supervision in the therapeutic sense. Fowler (1997) makes the point that where the needs of the nurse are clearly defined, the nature of clinical supervision is more easily identified. The umbrella terms "clinical supervision" and "mentoring" cause more confusion. Little has been written from the point of view of the supervisor or the supervisee to provide more evidence as to what the clinical supervision process is, and how it works.

Implementation can also be described in terms of group, individual supervision, managerial, or from line management, from peers trained in the process, and from practitioners trained in the process of clinical supervision, not necessarily from the nursing profession. No comparative data can be found which illuminates which way of implementing is most effective, apart from some anecdotal comments that practitioners ought not be ordered to attend as clinical supervision is not a disciplinary or punitive measure. It is also important to note that little effort is made in the nursing literature to define these very different processes. Commonly, individual and group supervision are assumed to be the same thing. They are not. Williamson et al's (1999) review article reveals, yet again, no clear answers as the design of the few studies on group supervision are ill defined and designed. He refers to Butterworth et al's (1997a) study as the only one demonstrating some rigour in providing some evidence of group supervision as a means of stress reduction in nursing staff. Bishop (1994) does make the comment that a sound strategy for implementation is likely to ensure success of implementation. However, more explicit detail about the effectiveness of clinical supervision is lacking.

The paucity of published literature on the subject of implementation is disappointing considering the interest in clinical supervision by nurses. If studies were more explicit, it would hasten our understanding and perception of clinical supervision, point the way to getting started, as well as providing a more valuable body of knowledge.

Despite the "disquiet", many nurses have embraced the practice of clinical supervision with energy, enthusiasm and creativity. In a study by Sloan (1998 a) that involved focus group interviews with community mental health nurses, the aim was to find out what supervisees perceive as good clinical supervisor behaviours. The results identified ten most important supervisor characteristics. These were:

> "*Supervisor makes me feel comfortable enough to discuss my limitations*
> *Supervisor has the ability to develop supportive relationships*
> *Supervisor inspires by his or her knowledge and clinical skills*
> *Supervisor is a role model*
> *Supervisor is committed to providing supervision*
> *Supervisor is perceptive to supervisee's needs*
> *Supervisor is actively supportive*
> *Supervisor has good listening skills*
> *Supervisor acknowledges his or her own limitations*
> *Supervisor allows supervisee to set agenda"*
>
> *(Sloan, 1998a p 42).*

In studies by Pesut & Williams, (1990), and Worthington & Roehlke, (1979 cited in Sloan 1998b p. 46) good characteristics of supervisors as identified by supervisors include:

- giving feedback about supervisee's counselling ability
- giving specific ideas about interventions
- creating a warm and supportive relationship
- promoting autonomy
- being competent as a therapist

Although this area of supervisor and supervisee preferred behaviours is lightly researched, there are similarities between what supervisors and supervisee's perceive to be the good qualities.

Although a definition of supervision can be selected from descriptors, a perspective from the recipients must be considered alongside it. An expansion of the concept as above is useful, however the specifics of the process remain elusive. Although the supervisors referred to in this study were trained supervisors in the mental health field, the way the above characteristics were expressed could apply to line management processes.

Scanlon and Weir's (1997) article on ten experienced mental health nurses' perceptions and experiences of clinical supervision used semi-structured interviews. She demonstrates some evidence that mental health nurses are becoming better at reflecting on the nature of their own formative learning. They also take seriously their need for professional support in striving for a more therapeutic patient relationship. All participants had a positive attitude to clinical supervision, but unfortunately, all to often the reported "good enough" clinical supervision was the norm. One of the reasons for this was the practice of managerial supervision, and recipients' inability to share openly. This has implications for the value of using experienced clinical supervisors trained in the process end being expected to deliver clinical supervision. One assumes cost must be a consideration with the expectation that managers will deliver clinical supervision.

Bulmer (1997) describes his study of 136 participants receiving clinical supervision. Results demonstrated that 1:1 supervision was favoured the most by providing new learning, and ability to share more personal feelings about their clinical work. Qualities of a good supervisor included being trustworthy, having good listening and analytical skills, giving constructive criticism, being supportive, facilitating rather than directing, giving positive feedback, and being non-judgemental. These match qualities found by Sloan (1998a).

An earlier UK postal survey described in Bishop's 1994 article had only a .2% response rate. Reasons given for this were high workloads and lack of interest by nurses. In a later 1998 survey by Bishop (1998) a 67% response rate was gained demonstrating a stronger interest and commitment to contributing to the

professional debate. Mailed questionnaires were sent to named nurse executives. Results demonstrated successful implementation of clinical supervision occurs only after a planned strategy, and when the uptake has increased. Success is dependent on creating a culture where staff are valued, demonstrated in terms of time for personal development, and on the role of the supervisor. However, no mention was made as to which model of clinical supervision was being studied, therefore this form of the process remains unexamined.

Bowles and Young's (1999) evaluative study based on Proctor's three function interactive model of clinical supervision is one rare example of an evaluative study on a specific model of delivery of clinical supervision. This study, on the benefits for eleven nurses, aimed to assess and compare reported benefits of the three functions of: accountability; skill development; and support. Also, 662 copies of the questionnaire were posted. The response rate was 30.4%. Reported benefits were equal across all three functions challenging the assumption that nurses are unprepared for clinical supervision. Findings also indicate nurses' avoidance of dual role supervision conflicts by seeking supervision outside of their immediate clinical environment. The length of experience was positively correlated to reported benefits. Another finding suggests that contract use did not lead to increased reported benefits. The researchers also devised a statistical instrument with which to measure Proctor's three functions that they claim is valid. Evaluating specific clinical supervision models of delivery aids our understanding of this process in nursing practice.

White et al (1998) carried out a multi-site study in the UK of 34 nurses experiencing clinical supervision. The aim of the study was to begin to comprehend the experience of the "insider world" of having clinical supervision. All respondents had not had previous experience of clinical supervision. A variety in workplace provision was experienced by respondents. The most common arrangement was 1:1 supervision. Most respondents did not know about available models of process. The content of clinical supervision sessions clustered around three areas. Clinical incidents in practice dominated, with

organisation and management including difficulties with interpersonal relationships, and tension between managerial and clinical staff. Theme three was education, training and personal development with elaboration on issues relating to staff morale, confidence and assertiveness. Personal value to practice, preparation for supervision, concern about a useable definition, and related benefits to feelings of wellbeing were cited. The value of being listened to, and the chance to discuss harrowing experiences, were also stated benefits. However, this study does not demonstrate improvement to patient care.

Cutcliffe (1997) comments on Butterworth et al's (1997) multi-site study results that suggested receiving clinical supervision benefits the recipient in terms of preventing emotional exhaustion and depersonalisation. Results are less conclusive when compared to previous evaluative studies. Clinical supervision may be good for mental wellbeing but cannot be described as irrefutable evidence that it is beneficial to both supervisor and supervisee. A concern of this large multi-site, multi-delivery mode study of clinical supervision was that it has not mirrored other small evaluative studies. A possible reason was the wide variety of amount of preparation recipients had had on clinical supervision, as there was for the study of supervisors. Therefore, if supervisors are not properly trained, then the quality of the supervisory experience will suffer. However, Butterworth's recommendations are comprehensive, and give some direction to improvement and development of the process.

In summary, there remains a disquieting lack of evidence on, and attempts to measure, improved patient care as a result of staff receiving clinical supervision. In particular, evaluation and audit do not appear to be a requirement of its implementation. Those studies that have attempted to evaluate clinical supervision in nursing have focussed on how nurses are implementing it, training, nurses' understanding of it, and what the benefits for the nurses are. However, for the time being, Butterworth's 1997 evaluative study is the more comprehensively designed, but again diluted by the lack of clarity of terms and structure as to what form of clinical supervision the nurses in his study are using.

A brief overview and written references of models of clinical supervision are outlined in figure 2 below. The author is not trained in delivering a variety of, nor had experience of receiving a variety of models of clinical supervision. Therefore, analysis and in their relationship to practice is therefore general, and an area for further investigation. Williamson et al (1999) refer to few nurses being aware of models of supervision during the course of their evaluative focus group study on the benefits of group clinical supervision for nurses. This is to be expected due to a dearth of useful evaluative data on the benefits of specific clinical supervision models. The following table adapted from van Ooijen 2000 and stated authors, sets out models of clinical supervision in order of chronological development as a beginning reference for further clarification.

Moreno (1948) Role Theory Model (cited in Consedine, 1995, p 3 unpublished)
Berne (1961) Transactional Analysis Model (cited in Holyoake, 2000)
Milne (1986) Triadic Model (cited in Farrington, 1995, p 877);
Heron (1990) Six Category Intervention Analysis Model (cited in Farrington, 1995, p 876);
Proctor (1991) Practice-Centred Three-Function Interactive Model (cited in Nicklin, 1997, p 52). Also adapted by **Nicklin** (cited in Sloan, 1999, p 525).
Ramirez (1991) Multi Cultural Model (cited in Farrington, 1995, p 877).
Faugier (1992) Growth and Support Model (cited in Farrington, 2000, p 877).
Hawkins & Shohet (1993) Integrative Approach or Double or Two Matrix Model.
Holloway (1995) Matrix Model (cited in van Ooijen, 2000, p 15).
Carroll (1996) Seven Tasks or Linear Model (cited in Van Ooijen, 2000, p 19).
Brown & Bourne (1996) Discipline-Specific Models (cited in van Ooijen, 2000, p 21-22).
Rogers & Topping-Morris (1997) Problem-Oriented Model (cited in Sloan, 1999, p 525).
Johns (1997) Reflective Cycle Model (cited in van Ooijen, 2000, p 6).

Figure 2. The Chronological Development of Named Models of Clinical Supervision

Van Ooijen (2000) classifies clinical supervision by theoretical background -see figure 3. It is discussed ove in much detail in Chapter 1 of her book "Clinical Supervision A Practical Guide".

DEVELOPMENTAL	APPROACH-BOUND
Derived from developmental psychology. Primarily emphasises educational function. Useful for nurses- emphasis on training & educational function. 18 models (Holloway, 1995). Integrated into a "combined developmental model of 4 major stages of supervisee development" Similar to Benner's novice to expert concept. Adapted from Hawkins & Shohet and applied to nursing: **Level 1 (child, novice)** **Level 2 (adolescent, journeyman)** **Level 3 (young adult, independent craftsman)** **Level 4 (mature adult, master craftsman, expert).**	Developed originally as part of counsellor or therapist training, practiced according to a therapeutic approach on which training was based. **Person-centred** **Advantage**: supervisee is practicing and receiving approach with supervisor role modelling Useful process guide. **Disadvantages:** easy to blur boundaries, appropriate to have processes not used in counselling
STRUCTURAL	**PROCESS**
Cyclical Model- a comprehensive approach for all supervision. Provides step-by-step guide from first meeting-a "blueprint". Developed for counselling but lends itself easily to adaptation for nursing. **A 5 stage process; contract, focus, space, bridge, review** (Page & Wosket, 1994 cited in van Ooijen, 2000). **John'sReflectiveModel-**Specifically designed for use in nursing, influenced by work of Carper (1978). **Focus,Whathappened?-Reflection**(aesthetics, personal,ethics),**Alternatives**(empirics, reflexivity),**Change/Action/Evaluation** (reflexivity). **Matrix Model-** clear structure, approach also developmental, used in US. Goal-to connect theory to practice. Meets 4 needs- descriptive, common goals, discover meaning, systematic mode of inquiry to determine objectives and strategies. Combines theory, research and practice Supervisory relationship core with dynamic relationship with **6 dimensions- institution, supervisor, functions, clients/patients, trainee, tasks.**	**Double or Two Matrix Model-** Concerned with only part of supervisory process, does not include contextual or organisational factors. Consists of 2 overlapping circles representing nurse/client (therapy matrix) and supervisor/supervisee (supervision matrix) relationships. Further subdivisions into 2 main styles- refect together on work done, use of here and now of supervisory session. Can usefully be combined with developmental model. Difficult to comprehend unless having it oneself. **7 Tasks of Supervision or Linear Model-** focus on process, series of frameworks, based on 7 summative or foundation tasks across models. Developmental. Tasks- create learning relationship, teach, counsel, consult, evaluate, monitor professional/ethical issues, work with administrative/organisational aspects of client work. Less helpful in nursing as it addresses the "what' not the "how".

DISCIPLINE-SPECIFIC	
Beginning to be developed for specific disciplines. **Social work (Brown & Bourne, 1996) "a map of the terrain"**, recognises SW work as part of a larger system, work with recipients. **Model based on 4 systems- practice, worker (supervisee), team, agency.** **Relevance to nursing, may take form of peer counselling.**	

Figure 3. Classification of Clinical Supervision by Theory or Function (adapted from van Ooijen, 2000)

This information is more likely to have meaning for those who have had clinical supervision training. Specific illumination by a clinical supervisor trained in teaching these models is required for increased understanding of the value of these models for nurses

Figure 3 begins to outlines more clearly how the models operate, as well as which ones are likely to suit nursing. Irvine (1998) describes Faugier's 1992 model. Faugier described guidelines for a positive supervisory relationship where the supervisor's role facilitates growth, and provides essential support for the practice of clinical excellence. Key elements are: generosity; rewarding; openness; willingness to learn; thoughtful and thought-provoking; humanity; sensitivity; uncompromising; personal; practical; orientation; relationship; and trust. This model represents a framework for the educational and training requirements to be considered prior to a service being set up. The model in-depth is a useful framework based on psychotherapy concepts but somewhat cumbersome. It also does not clarify the exact nature of clinical supervision. The most commonly quoted model, and the one with specific evaluation is Proctor's (1986) three-function model well-described by Bowles and Young (1999). Supervision is described as a working alliance with formative (educational/developmental), normative (managerial but not in the sense of managers as supervisors), and restorative (supportive/refreshing) elements.

SUMMARY OF REVIEW ARTICLES

Several review articles have been published on the subject of clinical supervision and four are utilised for this discussion. Fowler's (1996) review of the organization of clinical supervision within the nursing profession found that although there was a considerable amount written on the subject by nurses, there was little structure on organization in terms of theory and practice. Due to the unclear meaning of clinical supervision, the author developed a structure for review that covered five areas. These were: the *need* for clinical supervision within nursing practice; identification of *how* the concept is used in practice; the profession's *perception of good practice* regarding supervision; identification of various *models*; and the preparation of *training* for the role of supervisor.

Fowler concludes that the concept of clinical supervision in the UK dates from descriptions from the 1980's with three terms in common usage. They are "mentor, "preceptor" and "clinical supervisor". There is confusion within the profession regarding the use of these terms. Despite the lack of empirical evidence, the concept of clinical supervision has had wide acceptance. Where it has developed, it has been ad hoc. With the recognition that nursing has moved away from task oriented care approach to one of individualised and holistic care, the idea of nurses becoming practitioners in their own right and having individual accountability for their own actions has developed. Establishing nursing as a profession, the recent development of the therapeutic nature of the presence and actions of the nurse, the subjective nature of the caring aspect of nursing, and recognition of the use of a formal structure by other professions has promoted the idea that nurses would benefit from following similar ideas and practices.

The idea of supervision in nursing is a well established procedure within pre and post registration education. Preceptorship developed as an educative role. The more recent role of mentor and clinical supervisor are confused. No analysis of identification of need or benefit can be demonstrated, although the terms are in

common usage in the language. Perceptions of good supervision, and the desired characteristics of a good supervisor have only been measured in a descriptive and subjective way, with no evidence of benefit to other stakeholders such as employers and patients.

There are very few well-defined, precise models of supervision in the literature conveying more philosophy than details of a working model. Three major categories as described by Faugier & Butterworth's 1993 position paper cited in Fowler, 1996) are: supervision in relation to the supervisory relationship; describing the main functions of the role; and developmental models which emphasize the process of the supervisory relationship. Several writers confuse this relative clarity by incorporating terms such as "mentor", "role model", "facilitator" and "preceptor" which obscures clarity of meaning. As Fowler comments, most authors write about role identification, with more clarity defined by Barber & Norman (1987 cited in Fowler, 1996, p 475) as educational, managerial, supportive and the development of self-awareness, which in themselves are broad terms.

Because of the paucity of empirical evidence supporting the success of the process, constant reference to unpublished work results in uncritical repeating of non-researched statements. For example, reference to training initiatives produces anything from 2 to 15-day courses. There are some accounts of nurses being considered a supervisor simply by manner of their position. Little documentation exists on evaluation of the effectiveness of training. There is also more training of students in the preceptor role compared to that of the more therapeutic model more akin to that which counsellors and social workers receive. These results are disappointing if nursing is to develop a comprehensive, effective plan for clinical supervision.

In 1998, Sloan's (1998a & 1998b) review focussed on evaluating research into supervisor perceptions and attributes of good clinical supervisors. These benefits and advantages are covered in the section on Evaluative Studies. Few studies have focussed on supervisee-supervisor relationship, and particularly, the

supervisee's perception of the characteristics of a good supervisor. Beginning research in this area has had both a quantitative and qualitative orientation using rating scales for data production. Findings from the studies of Heppner & Roehlke (1994 cited in Soan 1998) and Rabinowitz et al 1986, Worthington 1984, & Worthington & Roehlke 1979 (all cited in Sloan, 1998, p 45) do begin to illuminate an important aspect of the supervisory process, namely the characteristics of a good supervisor as perceived by the supervisee. Fowler, 1995 (cited in Sloan, 1998, p 46) has expanded on this by his qualitative approach in gaining supervisees' perceptions of clinical supervision. Sloan (1998b) carried out a series of focus group interviews to determine a definition of clinical supervision. His findings revealed the five major categories of: who provides it?; what happens during the sessions?; factors affecting the choice of supervisor; characteristics of a good supervisor; and the limitations of clinical supervision as a result of how clinical supervision is conducted.

Further findings in Sloan (1996) revealed ten most important supervisor characteristics. An interesting finding was that more emphasis was placed on the supervisor's ability to provide a supportive relationship than actually providing it. Participants also placed less emphasis on their own practice being observed that observing their supervisor at work. In fact there was great reluctance among the participants having their practice observed. Sloan makes no mention of which model of supervision was under study, which leaves the reader with more questions than clarity.

Finally, Williamson et al's (1999) review of the effectiveness of the group approach to clinical supervision in reducing stress demonstrated the lack of research evidence that clinical supervision does in fact reduce stress. It may not mean that it is not valuable, and consensus exists that clinical supervision is beneficial at reducing stress in nurses. His reference to Butterworth et al's (1997a) evaluative study (cited in Williamson et al, 1999, p 338) is the only study directly relevant to investigating the stress-reducing potential of the group clinical supervision approach. Again, the concern is raised by Williamson et al (1999) that most studies lack rigour. As well, group supervision is included here as if it

was the same process as 1:1 clinical supervision. Further studies are recommended to replicate the work of Butterworth (1996, cited in Williamson et al, 1999, p343) and Butterworth et al (1997, cited in Williamson et al, 1999, p343) using identical measurement tools. The challenge by Williamson et al is for further research that will generate theory that can be utilised by nursing rather than using an "imported " model used by others. That current models may not be effective for nurses is all very well, but how can something be measured or developed if it has not been defined?

All of the above literature reviews draw attention to the dearth of empirical evaluative research data, as well as the subjective focus on the supervisee. Increasingly, the way forward points to the value of clinical supervisors being trained in a variety of methods so they can be measured, as well as the most appropriate one being utilised for the supervisee. The quality of the supervisor-supervisee relationship is imperative for any model to work. However, whether there is value or even if it is possible to research the effects of a particular model remains to be seen. What is becoming urgent is research that demonstrates benefit to nursing and benefit to patients.

SUMMARY

It is likely, in the near future, that unless there if proof of tangible benefits to nursing and patients from empirical studies on clinical supervision, in the therapeutic sense, there may not be much enthusiasm from some employers to purchase it. Alternatively, clinical supervision may only be afforded for a few, or maybe nurses will have to pay for it themselves if they can afford to pay for it. Cost and unknown benefits will be factors in whether clinical supervision will be incorporated into nurses' practice and paid for by the employer. The lack of clear definitions, the difficulty of describing a dynamic process, the variety of models used, plus lack of standardisation of training schemes and modes of implementation are all areas which require standardisation and adherence to guidelines for future effective development and research. Although there are some useful studies demonstrating possible benefits to nurses' well-being and professional development, evidence is scant. Research evidence that informs the use of implementation, models used, and handbooks clarifying the practice of clinical supervision are an urgent priority.

Health care budgets are becoming smaller while the cost of much medical care is soaring. In the near future, the aging cohort of the young elderly will be much larger that in the past. Many will be living longer with chronic illness that will cost more than in the past. Clinical supervision for all nurses may not be possible, unless there is good evidence.

A priority for New Zealand is for those workplaces who have evaluated clinical supervision to publish their findings, using as clear definitions as is possible. A national survey to demonstrate a profile of those nurses who have clinical supervision is necessary to gain the level of interest, practice, cost and implementation of what is practiced here. Research on specific models would be useful, as well as outlines and evaluation of training programmes available in or near to New Zealand. Nurses must speak out more about what they experience

in the name of clinical supervision. Because the process is bound by confidentiality, much of the nature and value maybe lost to other practitioners. A key concern is the use of managers performing clinical supervision which is not to be encouraged. Therefore, recommendations from this study are:

- Implement a national survey to reveal current understanding and practice
- Design national guidelines for training, implementation and models of practice based on the best information available
- Integrate evaluative studies into any tertiary and workplace initiative to include measured benefits to patient care and professional practice of nurses
- Explore and assess training opportunities for clinical supervisors

Bishop (1994, p 36) sets out possible benefits, gains and processes for clinical supervision which can assist with the above recommendations. The following table adapted from Bishop (1994) are set out below:

Box 1. Broad benefits gained through clinical supervision

- Improved patient care through reflective practice
- Support for professional staff development
- Compensation for flattened professional hierarchies, isolated professionals in the service
- Dissemination of good practices, shared learning and skills

Box 2. Gains for purchasers and providers

- Improved patient care-quality indicators
- Reduced turnover of staff (motivation and support)
- Cost-effective use of training/education budget

Benefits for those persons being supervised:

- Peer review
- Development of the role
- Up-to-date exchange of professional issues
- Developing a sharing collegiate culture
- Job satisfaction
- Potential for improved patient safety

Processes for clinical supervision

- A clear understanding of the definition and aims
- Clear feedback mechanisms
- Confidence in the supervisor
- Skilled listening and skills sharing
- Time allocation within the workplace
- Clinical supervision skills-ability to make sessions productive

Figure 4. Benefits, gains and processes adapted from Bishop 1994.

The author identifies with much of Bishop's identified factors from her own experience and development of understanding the process of clinical supervision for role development. In particular, professional development in terms of increased self-awareness in the teaching/facilitation role, improved awareness of my behaviour in terms of group safety and facilitation, teamwork, and problem solving and strategising. The fundamental aims of incorporating clinical supervision into nursing practice are to safeguard standards, develop professional expertise, and the delivery of quality care. Independent and cross-boundary working is on the increase in nursing, with more nurses at advanced levels working autonomously, and with increased workloads. The time has never been more right for clinical supervision to be further incorporated into nursing practice.

APPENDIX 1

PRACTICE HISTORY

Currently, I am practicing in the position of Education Programme Director for a New Zealand inner city hospice/specialist palliative care service. I have held the position for eight years. This has involved the design, administration, development and implementation of a comprehensive hospice/palliative care education progamme for health professionals, students of the health professions, hospice volunteers, and the wider community.

I first discovered clinical supervision as a tool for health professionals in the early 1980's when I worked in the field of reproductive health. Some of the nurses I worked with were also counsellors and in discussion with them, and with social work colleagues, I discovered its existence. Having had several difficult experiences with clients that had substantial impact on our team, we employed a sexual counsellor to provide "group supervision" once a month for one hour. This turned out to be a haphazard happening, as well as one of unclear delivery. At that same time in another of my workplaces, some of my social work friends were also complaining about having clinical supervision from line management. It was becoming clearer that this model did not fit with a feminist framework, and was not seated in a relationship of equal power base. My early experience of clinical supervision was not impressive or helpful as a form of staff support for my colleagues or me. We were disillusioned with this experience, and an opportunity for professional development was lost.

DEVELOPING AN OPPORTUNITY

During early employment at the hospice I was working with the then quality assurance co-ordinator in preparing the hospice for accreditation through Quality Health New Zealand. At this time, within the hospice, staff support mechanisms were being reviewed. In discussion with a small group of those social work, counselling and nursing colleagues from hospice, oncology, district nursing and

mental health, who were already having clinical supervision, I explored further. They had incorporated clinical supervision into their practice, either because of professional requirements in the case of counsellors and social workers, or personal preference in the case of nurses. A growing awareness of my understanding of its merits was developing. This awareness was also stimulated by a social worker's presentation at the local cancer society (who were very supportive of nursing education) about the importance of self-care and the value of clinical supervision. It made sense to continue the exploration.

During this time, a practicing mental health nurse and educator in the South Island, New Zealand, Mike Consedine, was developing groundbreaking work in assisting some workplaces to further develop clinical supervision for role development. In particular, this was for mental health nurses, but he was also open to, and passionate about, working with nurses per se. This provision of clinical supervision for "role development", as well as teaching nurses to give clinical supervision to each other, by each other, was an attractive and innovative idea. He had been developing the focus on "role" since 1989. This model of supervision for role development, developed from Moreno's role theory in psychodrama, was seen as an ideal vehicle through which to teach nurses who may not have had sufficient training in mental health and personality.

It was a beleaguered nursing profession, that was attracted to something that would support nurses at a deeper and more sustaining level than maybe other forms of staff support. Practicing in the context of the health cuts of the late 1980's and 1990's due to blown budgets and the introduction of a business model for health care delivery, nurses were bearing the brunt of changing, impoverished, and increasingly stressful working environments. Witnessing the benefit of the value for patients working through issues of emotional and practical difficulty, in their oncology and palliative care/hospice practice, is nothing new for nurses. Some have seen parallels in clinical supervision with the results of close communication processes staff working in palliative care witness and facilitate with people living and dying with terminal illness. Mental health nurses in the area were, at that time developing improved working conditions, which included

clinical supervision for more staff, as well as a specialist education programme. The application of clinical supervision, as a requirement, was being further developed within this.

During this time, the hospice employed Mike Consedine to train some nurses from hospice and associated services in clinical supervision for role development. They came from the hospice (of which I was one), cancer society, community health, and the oncology unit. It was envisaged that these nurses would be trained to a point where they could offer clinical supervision to hospice nurses, as well as nurses in their own workplaces. At the same time, the local hospital was utilising the same training programme in their contexts. It was envisaged that all nurses, trained in this model, would provide a substantial pool of nurses trained and experienced to provide a clinical supervision service for each other. Because of the wider group, it was also envisaged that more nurses would take it up if they were in a position to choose from a pool of supervisors outside of their immediate work service.

In 1992 the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) had included clinical supervision as a requirement for all nurses in the UK. This included a directive that senior nurses or nurses in management trained in clinical supervision, would provide this service. In New Zealand, a nurse psychotherapist Hazel Irvine, also trained in the process of clinical supervision and psychotherapy, was a recipient of a Churchill Fellowship in 1997. The proposal, which won her this award, incorporated a research field trip to interview the leaders in clinical supervision for nurses in the UK. Irvine (1998, unpublished), aimed to gain access to their written documents and interview some of the implementers. The results of this research exposed complex issues and problems in the implementation of this "grand plan" in the UK on the one hand, and exciting and innovative practice on the other. Therefore, although the literature may not reflect a clear account of clinical supervision, personal experiences were described by Irvine.

TESTING THE RESPONSE

Being exposed to the training raised my awareness of the process of clinical supervision. I informally asked as many people as I could about their experiences of it. I found varied, but on the whole, enthusiastic responses, coloured somewhat by some who were concerned that nurses could benefit from having it. Nurses work in such intimate situations often with no witnesses to assess their communication and relationship skills in these moments. For the majority who had supervision from someone outside of their workplaces, they thoroughly valued it, some even saying it had helped keep them at work through difficult times. Others, although benefiting from line management supervision, always had some reticence to being completely open. Others were in reciprocal processes with colleagues who were also friends. Through the 1970's and early 1980's, clinical supervision was little understood in the New Zealand nursing world, and although today, more nurses understand it better, there are still many who do not. The same can be said for managers. It is probably accurate enough to say that significant numbers of nurses remain sceptical either because they relate it to earlier experiences of being checked up on, or "snoopervision", or the cost and effort required to organise and pay for it. There is also considerable interest in the process, but this needs to be measured more accurately.

In 1994 I presented a paper with one of my hospice colleagues at the Hospice New Zealand conference in Hamilton on our experiences of implementing and evaluating clinical supervision. We titled the paper "Professional Supervision-a quality issue". Since we were exploring a quality programme, this concept made sense. The paper stimulated little response, apart from who paid. (Currently, several New Zealand hospices offer some form of clinical supervision to their clinical staff). That same year, I also presented a paper in Perth at the Australian national hospice/palliative care conference on the subject and had three responses from an audience of about 250 people. Again, the major concern was who pays, though counsellors, social workers and chaplains in the audience were very supportive of the practice for nurses. Later, in 1996 I presented a workshop on reflective practice with colleagues from Te Omanga and St Joseph's hospices at a Hospice New Zealand conference in Christchurch. At this workshop I made

some reference to clinical supervision as the "Rolls Royce" of reflective practice. On this occasion there was considerable response to the issue of reflective practice, but also many comments about the experience of receiving or giving clinical supervision. Anecdotal evidence from the audience suggested that nurses, in general, were hard to convince of its value, difficult to supervise, concern that management would not approve the cost, as well as not being able to afford to pay for it themselves. Child-care often took priority with available finances. However, there was also considerable enthusiasm from nurses who were receiving clinical supervision.

IMPLEMENTING CLINICAL SUPERVISION

We offered clinical supervision training at the hospice over a period of three years from 1993. The training consisted of three two-day workshops yearly over three years, plus a monthly support and practice group that we ran ourselves. Some of these nurses went on to supervise a small group of nurses. In that time there were three trainee withdrawals, which left a total of five people who completed the training. In the intervening time, from well into the training, we noticed that nursing staff in our service, and from outside, were not so keen to have colleagues or trainees give them clinical supervision. A further two trainees were lost for various reasons. Therefore, the original plan to use trainees from this programme never got off the ground for hospice. The key benefit from the training was that all participants had a much-improved understanding of the process, as well as improved communication skills. The majority actively sought clinical supervision for themselves.

POLICY DEVELOPMENT

It became evident, when we developed our hospice policy for staff support, including the provision of clinical supervision for clinical staff, and those working in "lone" senior positions, that there was some dissatisfaction with the naming of the process. We spoke of "professional supervision for role development", "supervision", and "clinical supervision", depending on our professional stance. After in-house consultation, we decided to name it "clinical supervision" to remain true to the original concept of this discrete process developed for therapists, with

the understanding that there were differing theories guiding training. We were very much aware from the training that clinical supervision was not therapy or mentoring, though some aspects of these modalities exist within the process of clinical supervision. We later changed the name to "professional supervision" as confusion remained with nurses and "managerial" supervision.

We were also aware that staff preferred clinical supervisors outside of the organization. The Education Programme Director and the CEO administer the policy within the hospice. Included in the policy is that supervisors employed by the hospice to provide clinical supervision must demonstrate evidence in their C.V. of the personal use of clinical supervision and training in it. The key intent of this policy was to provide high quality clinical supervision, which was not dependent on supervision from one discipline, but on the skill of the supervisor. Therefore, a list of willing clinical supervisors vetted by the Education Programme Director and the CEO was prepared and made available to all staff at an affordable negotiated rate. This implementation model continues as current practice.

CURRENT PRACTICE

In 2000, the hospice clinical supervision policy is under review. Both group and individual clinical supervision models are being practiced, and further considered, and continue to be named "professional supervision". Current concerns are that not many nurses take it up, nor do they all value it, nor do they attend regularly. Some feedback from in-house surveys (Robertson, 1994, Stroh, 1999, unpublished) demonstrated that those who have clinical supervision prefer 1:1 clinical supervision which, they believe, provides more personal and professional growth and soul-searching compared to the group process. This in part is due to the confidentiality aspect, but also more time is available for the individual with 1:1. Others who have only known group supervision claim that if managed by a suitably trained person it works very well for them. The issue of who is responsible for personal and professional growth has been discussed by senior staff and management. This includes the issue that management has some say in professional development if they are purchasing clinical supervision for staff

support, and running a specialist service. The issue of who is responsible for personal development and what the parameters of personal and professional growth are is also being reviewed. The aim of the review is to streamline what the hospice offers in an equitable and clear manner so that evaluation will be all the more valid.

EVALUATION

Since 1994, the hospice has surveyed its staff on their experience of clinical supervision three times. For those who receive it, they describe the benefits as being able to get away from the work environment and take stock of what they are doing; work at problem solving; restoring themselves; and work through strategies which enhance their clinical practice and their relationships with patients and staff. What is of interest is who takes up clinical supervision? Currently, of approximately 90 paid staff, 32 are having some form of clinical supervision (2 teams within the organization are also having group supervision). Approximately 2% of the nursing team are having clinical supervision, although several nurses in other roles are also receiving it. This illustrates that on the whole, nurses are reluctant to take the opportunity even when it is offered to them. Even when current staff are promoted and it is offered as an aid in the transition to the new role, they often have to be invited to take it up because they are not familiar enough with the concept. However, once started, most continue with it. Of those few nurses who have discontinued the process, apart from those who have left, state reasons for not continuing as being: "I don't have time"; "I get my needs met in other ways"; "my supervisor is not always available when I am", or "I can't get into it".

PERSONAL PRACTICE EXPERIENCE

Since 1995 I have been having my own clinical supervision from outside of the hospice from a nurse trained in counselling, clinical supervision, and education. The key areas I explore are: transference; the parallel process; facilitating groups; victim triangle; processes which enable me to examine my feelings; work planning; relationships; and evaluation of my performance. Sometimes I also use drawing interpretation to clarify issues. The effect is energising, and the result is

enthusiasm and excitement to develop further. Much can be achieved with intensive focus on one's work in one hour with a trained supervisor.

My own journey of clinical supervision has enhanced my practice through times of uncertainty and change. It has helped me to focus on *my* actions, rather than those of others. Improved setting of boundaries, problem-solving, strategising, and rethinking through issues and behaviours are specific topics for processing my work issues. Reflecting on what actually happened in a situation and how I might improve my actions if it were to happen again has assisted me to tackle new initiatives, and further my professional growth. Some aspects of my job are isolating as there only a few of us in this country who administer palliative care education. I value the opportunity off-site, uninterrupted, to have this time dedicated solely for me. Quite a proportion of my work is with groups, therefore, the immediacy of a 1:1 session enhances safe practice. This is a professional reason for having clinical supervision to process my work in facilitation. One might say I might be able to get this support from a manager. For one thing, the power imbalance will obscure the equal relationship, and I doubt that they would have the time, especially if they were to fulfil all their team's needs. None of any of my managers have had training. I benefit from other skills and experience my managers have. My workplace provides me with twelve, paid one-hour clinical supervision sessions in work time per year.

FINANCIAL IMPLICATIONS

There is a developing pattern of provision of clinical supervision for nurses in New Zealand and that is to offer 1:1 or group supervision in work time. As yet, there is no published data that can demonstrate what is happening New Zealand-wide in terms of how the process is implemented in the workplace, and what the effect is on nursing and patient care. There is no doubt that clinical supervision is happening here for nurses. Due to financial constraints, or maybe lack of leadership within nursing, as well as lack of managerial support, a lack of standardisation and understanding of clinical supervision is evident.

The average cost for a one-hour session of clinical supervision is around $60.00. There are some practitioners who charge from $20.00, through to those who also have a psychotherapy qualification who charge $90.00—$100.00 plus per session. On most nurses' wages this is quite an expense. It is enticing for employers to implement systems that utilise current staff who already have training, or run their own training, therefore, utilising managers as supervisors is tempting financially. There are still costs of both supervisees' and supervisors' wages when this is done in work time, but it would reduce the cost overall. However, the risks of training one's own staff would result in less effective supervision when supervisors are managers too. Supervision is a skill developed over quite some time assisted by previous counselling, communication, or therapy training. Quickly training staff could have the effect of a "quick fix", and risks reducing the impact that quality clinical supervision can have.

Is this what nursing wants? Or does nursing get what nursing wants –an exclusive nurse led clinical supervision for nurses by nurses? The alternative is being content with supervisors, regardless of what discipline, so long as the quality of the supervisory skills is high. It may be healthier for nurses to pit themselves more openly with a range of colleagues. Working in a less exclusive or narcissistic manner could enable nurses to be more visible members of a multi-disciplinary team.

IMPLICATIONS OF WORKPLACE KNOWLEDGE LOSS:

Mant (1997) discusses the potential loss of workplace knowledge when staff go off site to have clinical supervision or mentoring. He notes the trend to employ and support young intelligent and skilled managers who achieve high outputs, who also have supervision or mentoring outside the workplace. Therefore the "old" and "new" knowledge about the nature of their work may well be lost to the organization and other employees unless they are prepared to share their experience. The confidential nature of supervision and mentoring could well compound this concern. Mant also makes the point that in downsized organisations, especially those who employ younger and less experienced managers, now have considerable employees who are not managed. These tend

to be the ones who will seek out some form of outside support in the form of mentoring or "work counselling". In nursing, due to the very intimate nature of the therapeutic relationship (that involves the patient's body as well as emotions), clinical supervision provides a space for reflection and work on self in terms of professional development. A spin-off is that skills and perceptions gained from the experience of having clinical supervision will be transferred to colleagues in the form of modelling behaviour, sharing knowledge, and motivating others to be more reflective about their practice.

APPENDIX 11

LOCAL ACTIVITY

The table below sets out a "map" of the greater Wellington area where nurses are known to receive some form of clinical supervision by a person trained in clinical supervision. Because this information has been gained informally, it is only general and approximate. However, it does demonstrate evidence of the practice of clinical supervision for professional development since the early 1990's.

SERVICE TYPE & START DATE	LOCATION	1:1	GROUP	BUILT INTO TRAINING
Hospice 1993	Wgtn	Yes	Yes	No
Hospital 1999	Wgtn	Yes	Yes	Some
Medical Centre 1996	Wgtn	Yes	No	No
Child & Family 1997	Wgtn	Yes	No	Yes
Mental Health 1997	Wgtn	Yes	Yes	Yes
Critical Care 2000	Wgtn		Yes	Yes
Hospice 1997	Hutt	Yes		No
Hospital	Hutt	Yes		No
Child & Family 1997	Hutt	Yes	No	Yes
Mental Health 1997	Hutt	Yes	Yes	Yes
Mental Health	Por	Yes	Yes	Yes
Hospice 1997	Kapiti	Yes	Yes	No

Figure 5. Some clinical supervision practice in the Greater Wellington area as at 2000

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