

Clinical supervision: a concept analysis

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Clinical supervision: a concept analysis

Clinical supervision is a commonly discussed concept within nursing. There appears to be a common belief that it is a good thing for nursing. Many practitioners, however, are still unsure what clinical supervision is and what is expected of them. A number of definitions and models of supervision have been developed but it remains ill defined. This paper develops a conceptual analysis of clinical supervision using the method developed by Rodgers (1989). A review of the literature precedes description of the attributes, antecedents, consequences and references. A model case is outlined prior to a proposed definition of supervision being given. It is hoped that this paper will stimulate further exploration and study of this concept.

Keywords: clinical supervision, concept development, personal development, professional development

INTRODUCTION

Clinical supervision is a concept which is referred to frequently within the nursing literature but which is not well defined. There is widespread agreement within the literature that clinical supervision would appear to present nursing with a number of potential benefits (Paunonen 1991, Johns & Butcher 1993, Butterworth *et al.* 1997), although these have not yet been fully evaluated.

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC 1996) has stated that all nurses should have access to supervision. It would appear that in the United Kingdom (UK) the issue of clinical supervision is going to be important not only for nursing but also for employers of nurses within the foreseeable future. The author feels therefore that it would be useful to attempt to give some clarity to the concept.

Clinical supervision

Although there has been a wide range of literature related to clinical supervision there still appears to be a high

degree of uncertainty as to what clinical supervision entails. There are, however, a number of definitions within the literature. Clinical supervision has been described as:

...an exchange between practising professionals to assist the development of professional skills. (Butterworth & Faugier 1992 p. 12)

...the process whereby a practitioner reviews with another person his ongoing clinical work and relevant aspects of his own reactions to that work. (Minot & Adamski 1989 p. 23)

A practice-focused professional relationship involving a practitioner reflecting on practice, guided by a skilled supervisor. (UKCC 1996, p. 4)

The concept is implemented in a variety of ways, although in the author's experience it is frequently as a direct mandate from management with no accompanying directive or advice as to how it may be achieved. It can be assumed therefore that there is thought to be a common understanding of the concept. The reality is that nurses frequently are unsure as to what is being asked of them, which in itself may create resistance to its implementation (Cutcliffe & Proctor 1998).

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CONCEPT ANALYSIS

Concept analysis is essentially an imaginative process, seen as more of an art than a science. (Kitson 1993 p. 29)

The concept analysis method most often found in nursing literature is that of Walker & Avant (1988 p. 36) who believe that concept analysis is useful for a number of reasons, including 'to help clarify overused vague nursing concepts' and 'to produce a precise operational definition'. The approach has also been utilized by Chinn & Kramer (1995) who argue that concepts can be placed on a continuum from the more directly experienced (or empirical) to the more mentally constructed (or abstract). Chinn & Kramer (1995) believe that as concepts become more abstract they are less measurable. Those using other paradigmatic approaches would disagree. Those within the interpretive/constructivist paradigm, for example, would not use empirical indicators but would analyse each concept holistically. Walker and Avant's approach has been criticized as being reductionist and static (Rodgers 1989), as well as for being based in the positivist paradigm.

Rodgers (1989) has developed an evolutionary approach to concept analysis within which she argues that concepts are abstractions that may be expressed in a discursive or non-discursive way. Then:

... through socialization and repeated public interaction, a concept becomes associated with a particular set of attributes that constitute the definition of a concept. (Rodgers 1989 p. 332)

Rodgers (1989) believes that concept development has three phases: significance, use and application. This approach would appear to be useful when analysing the concept of clinical supervision.

THE AIM OF THE ANALYSIS

The method chosen for this analysis will be that devised by Rodgers (1989).

The aim of the concept analysis is to attempt to clarify the concept of clinical supervision in order to assist nurses' understanding of the concept and to raise awareness of what it is they are undertaking when they become involved in clinical supervision, and what they are being encouraged to become involved in by their peers as part of their role.

Analysis of the terms

The *New Collins Dictionary & Thesaurus* (1988) defines clinical as:

...of or relating to the observation and treatment of patients directly.

The *Shorter Oxford English Dictionary* (1986) defines supervision as:

The action or function of supervising; oversight, superintendence.

Based on these definitions clinical supervision *could* be defined as:

A controlling mechanism instituted to oversee directly the skills utilized in the treatment of patients.

The literature on the subject of clinical supervision attempts to describe a very different reality and therefore it is useful to review the literature.

Literature review

Butterworth *et al.* (1997 p. 2) state that most of the literature concentrates on 'philosophical debates, models, processes and methods of delivery'. They go on to say that 'Most accounts are based on individual enthusiasm, personal accounts and anecdotal reports'. In a brief resume of the literature they identify other themes including models of supervision, how literature from other professions has helped to shape the models used in nursing, the costs of supervision, and confusion of terminology.

Fowler (1996), in a more extensive review of the literature on clinical supervision in nursing, identified five areas into which the literature could be structured. These are the need for supervision within nursing, uses of the concept in practice, perceptions of good supervision, models of supervision and preparation for supervisors. Each of these areas will be briefly examined in turn, as this should enable some analysis of the differing natures of the concept.

Clinical supervision: the need within the practice of nursing

Butterworth (1991, 1992) was among the first to argue that formal support mechanisms for nurses were required and that these should take the form of clinical supervision. Work from other professions began to influence nursing and models of supervision from professions such as psychotherapy started to be used in nursing (Hawkins & Shohet 1989).

The Department of Health (DOH) (1993) identified clinical supervision as a key target to be achieved. They define clinical supervision as:

...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. (Department of Health 1993 p. 15)

It has also been argued that factors emerging from The Code of Professional Conduct (UKCC 1992a) and The

Scope of Professional Practice (UKCC 1992b) made the implementation of clinical supervision essential (Bishop 1994). Since that time the UKCC (1996) have also issued their position statement on clinical supervision. There are expectations that supervision will enhance the application of theory to practice (Smith & Russell 1991), will raise awareness of the therapeutic role of the nurse (Ersser 1991), and that nurses will benefit from following the lead of other professions in utilizing a formal structure of supervision, which in turn will aid the aim of identification of nursing as a profession. The author would also argue that increased pressure on nurses within the current climate in health care raises the need for more accessible support mechanisms which clinical supervision may provide.

Clinical supervision: uses of the concept in practice

Clinical supervision has been described in the literature as 'time for me' (Salvage 1998 p. 24). This statement presents clinical supervision as something for the nurses' benefit. Indeed it has been argued that one of the perceived benefits of clinical supervision is to relieve feelings of stress in those nurses taking part (Berg *et al.* 1994). This approach has been challenged by Yegdich (1998 p. 193) who argues that 'this emerging interpretation of clinical supervision "by nurses for nurses"' has meant, 'it has become acceptable to discuss anything and everything'. Yegdich (1998) goes on to argue that clinical supervision involves three people, supervisor, supervisee and the patient, and that all issues covered in clinical supervision sessions should relate directly to patient care. This, however, is not the approach that appears to be generally accepted in the UK, with clinical supervision being seen as a forum for both personal and professional growth. There is agreement that supervision is not to be seen or used as a managerial tool for discipline or control although there is evidence to suggest that this is how it is viewed by some practitioners (McCallion & Baxter 1995).

Nursing uses a number of terms to describe this process. Firstly there is the concept of clinical supervision which is well discussed in the literature and described by Butterworth & Faugier (1992) and Faugier & Butterworth (1993). Whilst Butterworth and Faugier (1992) attempt to define clinical supervision, they also acknowledge that it is an umbrella term. Secondly, there is the term mentor, which is widely used within nursing. Again there is a wide variety of definitions of the role. Thirdly the term supervisor, which comes from the English National Board (ENB 1993) which states that all pre- and post-registration students should have a clinically based supervisor who focuses on aiding students achieve course aims. The fourth term is assessor which the ENB (1993) define as a more formal role than a supervisor. An assessor is responsible for judging the

levels of attainment of pre- and post-registration students. The fifth term, preceptor, was introduced by the UKCC (1990) to identify a support period for newly qualified nurses and nurses moving to new work environments. It appears that the terms supervisor, assessor and preceptor have reasonably well-defined parameters and length of involvement. The same is not true of clinical supervision nor indeed of the term mentor which would appear to be substituted for the others at will. Fowler (1996) argues that the term mentor is ill defined, meets no specific groups' needs but is commonly accepted and will remain in use within nursing for some time because of this acceptance.

Clinical supervision: perceptions of good supervision

The literature from supervisors seems to concentrate on the benefits of supervision and any constraints to carrying out the role that are identified (Fowler 1996). Recipients of supervision are more forthcoming on what makes someone a good supervisor. Pesut & Williams (1995) found that psychiatric clinical nurse specialists believed a good clinical supervisor would give specific ideas, provide feedback, promote autonomy as well as possess traits such as warmth and competence. This would appear to support the view that supervision will provide both clinical development and support. Again in a study of psychiatric nurses Severinsson (1995) found that good supervision entailed a theoretical approach to caring which had a spiritual dimension. This was found to be important in the development of the nurses' identity. Fowler (1995) argues that there are qualities in a supervisor that are generally valued by all students such as an interest in the student and approachability, a knowledge of wider professional issues, and a willingness to negotiate with students regarding learning experiences. Fowler (1995) also notes that some qualities, notably having a supervisor who is knowledgeable regarding the practice area, are dependent on the experience and knowledge of the student. Sloan (1998), in a study of staff nurses, identified 10 characteristics of a good supervisor. These varied from an ability to form supportive relationships and having knowledge and clinical skills, to the need for the supervisor to be actively supportive, able to acknowledge their own limits and be committed to providing supervision.

In order to provide good supervision Whitman & Jacobs (1998) argue that a supervisor has responsibilities to the supervisee (education and standard setting), the patient (should be assured of good treatment), the profession (to maintain satisfactory standards among therapists) and also to themselves (to remain up to date not only in knowledge but also in maintaining an awareness of their own strengths and weaknesses). Although Whitman & Jacobs (1998) paper refers to psychotherapy supervision the

responsibilities to which they refer are transferable to the nursing setting.

What all these studies appear to have in common is that not only do nurses perceive knowledge and skills as important aspects of a good supervisor, but also nurses value other characteristics in a supervisor. These are characteristics that would enable supervision to be a process that not only encourages professional development but actively encourages personal growth as well.

Clinical supervision: models

A number of models of clinical supervision have been identified in the literature. It has been argued that the models used commonly have no empirical research evidence to suggest that they are either effective or appropriate (Maggs 1994). Faugier & Butterworth (1993) suggest the models can be divided into three types: those that focus on the supervisory relationship, those that describe the functions of the role, and developmental models that focus on the process of the supervisory relationship. Butterworth *et al.* (1997) state that the model suggested by Proctor (1991) whose key elements are normative (organizational and quality control), formative (education and development) and restorative (support for staff) is commonly accepted within nursing. There have been, however, a number of models of supervision developed within nursing in response to the differing needs of practitioners working in very different environments.

Johns (1993) has developed a reflective model of professional supervision based on a research study. Cutcliffe & Epling (1997) suggest a model of supervision that involves the use of confronting techniques. They argue that this is appropriate as both these confronting interventions and clinical supervision have increased self-awareness as a focus. Nicklin (1997), using Proctor's model as a basis, developed a practice-centred model of supervision. Nicklin (1997) argues that by sustaining a balance between various role functions, practitioner effectiveness will be increased. Rogers & Topping-Morris (1997) describe a problem-orientated model of supervision developed in a forensic psychiatric unit. Here both supervisor and supervisee identify clinical problems and then use problem solving strategies to provide a solution that is structured, focused, logical and measurable. They state that supervisors encourage and facilitate self-actualization of the supervisee.

Fowler (1996) argues that although much of the literature on clinical supervision is based on opinion, and experience and ideas from other professions, what will emerge is a consensus of opinion that can then be used to develop a model of clinical supervision suitable for nursing and midwifery. He goes on to identify three common elements which the model should address: that it should describe the function of the role of supervision within the profession, it should identify the constituents

of a supervisory relationship, and that it should describe the process of this relationship. One problem with this approach is that a model that is appropriate for one setting, e.g. mental health, may not work in another, e.g. acute or community environments. Therefore a number of available models are required so that practitioners can use one most relevant to their practice area. This may confuse practitioners, which in turn may increase resistance to the implementation of supervision.

Clinical supervision: preparation for supervisors

There is very little in the literature regarding the preparation of clinical supervisors. The experience of the author is that normally there is only 1 or 2 days preparation for the role. These are either study days, or time spent with other staff who have tried to implement clinical supervision without any formal training for the role. Cutcliffe (1997) argues for a formal training, which then leads to registration on a register of supervisors. Jones (1998) describes a programme to introduce nurses to the skills required to provide effective supervision. Rafferty & Coleman (1996) describe a module accredited by the Welsh National Board and the University of Wales, Swansea, that prepares supervisors for their role. Cutcliffe & Proctor (1998), however, argue that training practitioners to be supervisors, whilst realizing it is a specific skill, is costly and therefore a barrier to full implementation. They go on to argue that a more effective way of implementing supervision would be for its introduction into nurse training so that practitioners are already aware of, and comfortable with, the benefits and processes of supervision when they qualify.

Other professions

Supervision has long been a part of the practice of other professions. Within midwifery supervision has been statutory requirement since 1902 but generally is seen as a formal organizational/management process within the profession 'linking the professional hierarchy with daily clinical practice' (Curtis 1992 p. 96). Curtis goes on to argue that the supervisory process is 'tied into and compromised by the administrative structure' (Curtis 1992 p. 97). Supervisors have responsibility for ensuring that midwives within their jurisdiction complete notification of practice forms, that the appropriate authority is informed of practising midwives, and that all midwives have copies of midwives' rules, as well as being available to deal with practice-related issues (Bennett & Brown 1996). Gorzanski (1997) does, however, argue that the quality of midwifery is linked with the quality of supervision.

This idea of supervision being linked to quality assurance (Diwan *et al.* 1996) is also central to its practice within social work. Again senior social workers are

expected to take on the role of supervisor. However, Brashears (1995) argues that the supervision of social work has been defined as a separate entity from its practice.

Within counselling, supervision is a mandatory requirement for practice and supervisors have a code of ethics to follow (Pugh 1998). Whilst nursing supervision is not counselling, nurses do use counselling skills which may make provision of supervision useful. Proctor's (1991) elements of supervision were formulated in the practice-based professions of counselling and probation work, which may make this model suitable for nursing.

Within both social work and counselling, clinical supervision has been seen as a way of improving student teaching (Ford & Jones 1987), which would appear to be a different conceptualization of the process. They go on to state that this is how it has been used within psychiatric nursing as well. Within psychiatric nursing there is also evidence to show that it has been used as an administrative tool (Platt-Koch 1986). Within psychotherapy, supervision is a recognized process by which both students and qualified staff are prepared to become therapists (Watkins Jr 1995). He identifies 10 broad-based conclusions about supervision within psychotherapy. Among these are that therapists consider supervision relevant to their practice, that supervision is not in itself psychotherapy and that there is little preparation for the role of supervisor despite the recognition of the role as being important. These last two are paralleled in nursing, with some nurses perceiving supervision as a form of therapy and the lack of preparation for the supervisory role.

ATTRIBUTES OF THE CONCEPT

Although the concept of clinical supervision is seen as beneficial to nursing there is little guidance on how it should be carried out. There is, however, an increasing literature, which provides some evidence to suggest that supervision is beneficial for nurse practitioners. For clinical supervision to be implemented widely it will have to show benefits not only to nurses but also to the patient and the organization. Berg *et al.* (1994) found that systematic clinical supervision decreased the negative outcome of stress felt by nurses which was imposed by the burden of nursing care in those who were using individualized planned care. Berg *et al.* (1994) also claim that clinical supervision increases the creativity of nurses, which they suggest may enhance patient care. Hallberg & Norberg (1993) found that systematic clinical supervision, again in conjunction with individualized patient care, appeared to improve nurse-patient relationships and also reduced the experience of strain in nurses. However, Palsson *et al.* (1996) found that clinical supervision had little effect on burnout or empathy. They concluded that more research is needed regarding the effects of clinical supervision in nursing. Hallberg (1994) found that following systematic

clinical supervision nurses felt they had increased self-confidence and a broader and better knowledge base. Nurses were increasingly satisfied, with a lower degree of tedium although there were no changes in the degree of burnout. Cutcliffe & Epling (1997) argue that clinical supervision can raise awareness in practitioners, which it can be argued helps practitioners to understand how supervision contributes to patient care, the supervisee themselves and the organization.

Clinical supervision is seen as a process that should be for the benefit of the nurse as well as the patient and include personal growth, while some argue that supervision should focus on purely patient-related clinical issues enabling professional growth. There is agreement, however, that the process should not be used as a punitive one, but rather as a developmental process.

ANTECEDENTS

For the concept to be transferred effectively to the practice area the author believes that a clear understanding of the concept is essential. Once this is achieved both supervisors and supervisees will be aware of what is expected of both of them. This in turn will lead to more effective supervision.

For clinical supervision to be implemented effectively it would appear that there are three main areas to be addressed. These are the skills, resources and commitments that are required from participants.

Bulmer (1997 p. 54) found that the skills identified by nurses that were highly rated in supervisors were:

- trust-worthiness;
- being honest and open;
- having good listening and analytical skills;
- being supportive;
- giving constructive criticism;
- facilitating rather than directing;
- being honest about their limitations;
- giving positive feedback; and
- being non-judgemental.

Bulmer (1997) also found that nurses did not see it as vital that supervisors knew more than they did. It could be argued from this that nurses value supervision in part for its support mechanism rather than purely for professional development. Other skills identified as important in a good supervisor are interpersonal skills and communication skills, including the ability to listen and to provide information in a clear and understandable way (Pesut & Williams 1990, Fowler 1995, Sloan 1998). Fowler (1995) also identified relationship issues as important to supervisees. Sloan (1998) discovered that supervisees differentiated between a supervisor's ability to form supportive relationships and actually providing that relationship for the supervisee. The ability to reflect upon practice has

been identified as an important skill for effective supervision (Johns 1993).

There is a cost involved in setting up and providing supervision. It has been estimated that the cost for a medium sized NHS Trust to provide 1 hour of supervision a month to each nurse would cost in the region of £125 000 (Nicklin 1997). Nicklin (1997) goes on to argue that if the cost resulted in reduced sickness levels, improved clinical effectiveness and quality of care, a reduction in complaints and clinical errors, and increased staff morale, clinical supervision would pay for itself. There is an increasing amount of evidence to show that there are benefits to implementing supervision. Smith (1995) has argued that the cost of implementing supervision within a Trust is not a large amount of money when you consider that it is roughly equivalent to the cost of employing a National Health Service (NHS) Trust chief executive for 1 year. The other resources required are time, and somewhere to conduct sessions. Time needs to be found within the working day if supervision is to be implemented throughout nursing. There may be a sense of guilt on the part of the nurse who leaves the clinical area for supervision fully aware that it is busy and short-staffed. However, if there is not that commitment to providing supervision within the workplace it would very quickly become a low priority.

Commitment to the process is obviously required from the supervisor and supervisee. However, commitment is also required from managers (Wilkin *et al.* 1997). As the UKCC (1996) has stipulated that all practitioners are to have access to supervision, that commitment may well have to be made. The difficulty here may lie in how Trusts implement clinical supervision. Cutcliffe & Proctor (1998) also argue that the structure and culture of the NHS at present will not allow for the full implementation of clinical supervision.

CONSEQUENCES

It has been claimed that clinical supervision, if implemented effectively, will bring benefits as diverse as improved patient care through increased skills and knowledge (Butcher 1995), a reduction in stress levels (Butterworth *et al.* 1997), a reduction in complaints and an increase in staff morale (Butterworth *et al.* 1997).

Increasingly, reported work is identifying other benefits including increased knowledge and awareness of possible solutions to clinical problems (Dudley & Butterworth 1994), increased confidence and reduced emotional strain and burnout (Hallberg & Norberg 1993), increased participation in reflective practice (Hawkins & Shohet 1989) and increased self-awareness (Cutcliffe & Epling 1997). The benefits identified have implications not just for practitioners but also for patient care and employing organizations.

It could be argued therefore that a further potential consequence of effective supervision is that the nurse becomes more efficient, benefits are seen in patient outcomes, and that this increases patient throughput, putting more pressure on limited resources.

However, Wolsey & Leach (1997 p. 24) argue that:

Clinical supervision has yet to demonstrate its efficacy in improving outcomes for patients, systems and processes in the health service.

They go on to argue that the study by Butterworth *et al.* (1997) gives only the views and opinions of those involved, but makes no claims as regards patient outcomes.

Cutcliffe & Proctor (1998) outline a number of reasons for resistance to clinical supervision in nursing, including tradition and a culture which discourages expression of emotion, the perception of supervision as a management tool, the perception of supervision as a form of therapy, and a continuing lack of clarity regarding the purpose of supervision. Wilkin *et al.* (1997) argue that resistance is an unavoidable part of the process of change.

It has been argued that until clinical supervision has been fully implemented researching its effectiveness is of no use (Marlow 1997). The author would agree that until it is implemented the full benefits will not be seen but would argue that continued research into the benefits of supervision may be the only way of convincing employers to invest in supervision in the current economic climate.

There is the potential for clinical supervision to be implemented widely throughout the nursing profession. Perhaps if supervision is seen as a valuable resource some of the constraints to its implementation may be more easily addressed. It has been argued that:

It would be a scandal if yet another key nursing development were scuppered by flawed implementation. (Salvage 1998 p. 24)

Related concepts

As there still exists some degree of uncertainty as to what clinical supervision is there would seem to be a number of concepts, which may be related. These would include reflective practice, counselling, empowerment, education, preceptor, mentor, personal development, professional development and support.

MODEL CASE

The supervisee attends a pre-arranged supervision session with their chosen supervisor. The session takes place in a pre-arranged location where there is privacy and they will not be disturbed. The session takes place within work time with the knowledge and support of the supervisee's manager. The supervisee has a pre-arranged agenda, which

she has made her supervisor aware of prior to the session taking place. The session proceeds within pre-arranged parameters agreed at the initial session, which was used as a contracting session. Areas agreed include the recording of the session and by whom, non-judgemental or sexist or racist language, and confidentiality and its limits (i.e. issues showing malpractice by the supervisee). The supervisor is able to assist her supervisee with the problem highlighted at the session and the supervisee leaves the session ideally assured of her actions, with her confidence and morale raised. The supervisor has also been able to challenge some assumptions made by the supervisee, raising her awareness of her actions in certain situations. At the end of the session the next meeting is arranged.

CONCLUSION

Clarifying the concept of clinical supervision within nursing is not easy, as nursing is very varied in its practice settings. Butterworth & Faugier (1992) also warn of dangers in trying to give a tight definition of clinical supervision.

Proposed definition of clinical supervision

Based on the preceding analysis the clarified definition is as follows:

Clinical supervision is a support mechanism for practising professionals within which they can share clinical, organizational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills. This process will lead to an increased awareness of other concepts including accountability and reflective practice.

Relevance for nursing

Clinical supervision is a very important concept for nursing because of the potential benefits it can bring to patient care and nurses themselves, both individually and as a profession. Although there are barriers and resistance to the implementation of clinical supervision there is an increasing amount of evidence to suggest that the potential benefits can be realized. It is vital that nurses understand what is meant by clinical supervision and what it is they are being urged to take on. Nurses should also be aware that there may be different but equally valuable perspectives on supervision and not allow this to become yet another barrier to its implementation. As nurses are expected to take on greater responsibility an appropriate support network that encourages exploration of practice can only be of benefit. This paper has provided an overview of the concept by promoting an understanding of clinical supervision, which enables practitioners to fulfil its full potential. As nurse training now attempts to

provide nurses with the skills to practice reflectively, a forum to utilize these skills effectively should be grasped wholeheartedly.

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