Wicked spell or magic bullet? A review of the clinical supervision literature 2001–2007

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Summary Clinical supervision has become an established part of nursing. Implemented in various different ways it has attracted attention from the research, educator and practice communities. The literature reported and analysed in this paper describes work that may benefit professional practice but there continue to be questions about application and method. Two new messages arise from the literature. The first underscores the responsibility of health care organisations to sustain and develop clinical supervision and the second points to the potential benefit that clinical supervision may have on patient outcomes.
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Introduction

Accounts of clinical supervision and its value to nurses first appeared in the literature 17 years ago (Hill, 1989). The first text book on underlying theories and practical models emerged three years later (Butterworth and Faugier, 1992). Investigation into the subject has progressively developed since that early and innovative work until the present, where the potential effect that clinical supervision might have on patient outcome (Bradshaw et al., 2007) and the disposition of qualified clinical staff is generating interest. These new and developing trends offer timely opportunities for a literature review and a contemporary comment on progress.

Background

There is a sustained view that clinical supervision has become an important part of nurses' practice (Tilley and Chambers, 2003; Lindren et al., 2005).

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Several authors have argued that clinical supervision enables nurses to cope better with the changing nature of health care delivery including an increased emphasis on clinical governance (Wood, 2004; Marrow et al., 2002), decentralisation of decision-making (Hyrkäs et al., 2003) and movement towards community based care (Magnusson et al., 2002). Changes in practice and the delivery of care have led to increased autonomy, responsibility and independent working, which has negatively affected support mechanisms (Hyrkäs et al., 2003). This has necessitated the creation of practices to enable accountability and the development of new skills (Spence et al., 2002). Clinical supervision is seen to support new practice developments.

Aims of this review

Clinical supervision is seen to be an important part of nursing activity. There has been little recent analysis of the purposes to which it has been put and if new findings are emerging from its implementation.

This literature review aims to

- offer an analysis of themes arising from the literature that have emerged during the last six year period;
- describe any emerging trends and outcomes that are precipitated through the use of clinical supervision.

Literature review method and parameters

PubMed, CINAHL, Pre-CINAHL, Academic Elite were exhaustively searched for the terms ''Clinical Supervision'' combined with ''Nurse'', ''Allied Health Profession'' and professions listed by the Health Professions Council. The literature survey was confined to papers published between 2001 and February 2007. Literature before 2001 is only offered when it contributes to the discussion of the current literature. This paper builds on Gilmore (1999, 2001) presentation of the issues surrounding clinical supervision prior to this date. An initial analysis of 92 articles revealed a series of subject areas that have produced well considered publications. Critical reading using established tests of robustness, construction and originality allowed the authors to gather the literature within four main thematic groups:

(i) levels of engagement;
(ii) the usefulness of clinical supervision as an educational and supportive device;
(iii) ethical debate, personal and organisational challenges;
(iv) effects on patient outcome and staffing disposition.

Critical commentary on each of these four areas is offered at the conclusion of the paper.

Reports on levels of engagement in clinical supervision

Table 1 suggests reported current levels of engagement in clinical supervision. This varies widely (18% in practice nurses in Leicestershire in the UK to 85.9% for mental health nurses in Northern Ireland). This table suggests that the number of nurses receiving clinical supervision varies greatly between regions and disciplines. Many would argue that at the levels described in the tables below, nurses continue to receive an inadequate amount of supervision.

A number of studies have examined technological advances and new work practices to encourage the uptake of clinical supervision. Thompson and Winter (2004) describe a telephone clinical supervision scheme to increase clinical supervision activity within a Primary Care Trust. Nurses arranged a convenient time for a supervisor to ring them and the latter used a database which prompted them regarding questions to ask and notes to take. The effectiveness of this supervision was not discussed, however the project reported an expansion of activity, which the author deemed as success. Similarly, Marrow et al. (2002) trained 40 nurses in clinical supervision and video conferencing technology to enable long distance supervision. Using a mixture of focus groups, pre- and post-study questionnaires, repertory grids and written narratives, Marrow et al. (2002) reports that rural nurses benefited from clinical supervision using video conferencing technology. They preferred this visual communication to using telephone or email.

Table 1 also suggests that studies of clinical supervision vary widely in terms of the amount of training received and the number of hours devoted to clinical supervision. Hyrkäs (2005) points out that many studies report shortage or even absence of training thus making them difficult to critique. Short duration of clinical supervision inevitably affects the likelihood of clinical supervision being effective. In Edwards et al.'s (2005) survey of 815

Table 1 Reported levels of engagement in clinical supervision

First author	Year	Country/ region	Type of nurse/ discipline	N (response rate)	Number that are receiving supervision	Number that are providing supervision	Training of supervisor	Choice of supervisor	Type of supervision	Number of hours of supervision
Cheater (project to increase supervision rates)	2001	UK Leicestershire	General practice	Between 65—70%	18%	18 supervisors	Two day training course	N/A — no choice, but no supervision by managers	Combination of group and individual, depending on topics	Minimum 3 h annually
Kelly	2001	Northern Ireland	Mental health	153 (61.2%)	81%	39.9%	59.6% trained	55.6% allocated a supervisor, 40% line manager		
Teasdale	2001	UK (Trent)	Various[a]	211 (40%)	45%			56% chose supervisor, 22% chose manager, 65% were allocated manager	41% individual supervision, 40% group supervision, 19% both	
Edwards	2005	UK, Wales	Community Mental Health (CMH)	260 (32%)	84% had 6+ sessions			62.4% chose supervisors	73% individual supervision, 17% supervised as a group, 8% both	57% monthly sessions, 44% sessions lasted 46—60 min
Magnusson	2002	Sweden	CMH	660 (57.9%)	50.9%					
Hyrkä/rows	2005	Sweden	Psychiatric	569 responses	85.9%	24.1%	60.3% had training, 33.8% Some psychologic at training, 5.8% none	78% chose supervisor	64.3% individual, 35.7% group	92.8% 1—2 times a month, most had 45—60 min sessions

[a] Nurses were divided into medical, surgical and community. Please see study for rates of supervision reported by discipline and gender.

community mental health nurses across Wales, they found that a clinical supervision was most effective when clinicians engaged in it for 45 min to an hour per month. Cheater and Hale (2001) found that effects were only beginning to be visible towards the end of their study period when attitudes towards clinical supervision were beginning to change. There is little evidence in the literature to suggest what might be a 'gold standard' for the amount of time and necessary frequency for clinical supervision. Location, nature of practice and organisational requirements affect frequency and duration in quite serendipitous ways, making it difficult to be prescriptive.

Clinical supervision as an educational and supportive device

The educational and supportive nature of clinical supervision is the most frequently discussed and reported theme in the literature.

Nurses who have experienced clinical supervision suggest that some of the most important advantages are restorative. In qualitative evaluations of clinical supervision, they cite the growth and development of personality (Žorga, 2002), increased confidence (Marrow et al., 2002; Žorga, 2002) and a decreased sense of professional isolation (Bedward and Daniels, 2005; Jones, 2001). Clinical supervision reportedly increases nurses' awareness of themselves and their ward milieu (Johns, 2003) including a deeper awareness of their ways of thinking, decision-making and performance (Spence et al., 2002). This is particularly evident when nurses are asked to cope with difficult situations, such as loss, death and suffering and difficult emotions including guilt (Jones, 2001). It is also reported to have enabled nurses to cope better with these difficult situations to achieve a more balanced work life (Jones, 2001), recognise personal feelings and look after their health (Žorga, 2002). Interestingly, there are reportedly improved relationships with friends and family (Jones, 2001) as well as positive effects on their relationships with managers (Cheater and Hale, 2001), motivation and responsiveness (Jones, 2001). However, some studies reporting restorative benefits to nurses have produced mixed results. Willson et al. (2001) evaluated a one year trial of monthly clinical supervision using pre- and post-implementation questionnaires. They found that whilst nurses reported reduced stress levels in open-ended questions, quantitative evidence gathered using Likert scales did not support qualitative evidence. Fur-

thermore, in a survey of nurses in the Trent area, Teasdale et al. (2001) found that they could not confirm a relationship between burnout, as measured by the Maslach's Burnout Scale (MBI) and clinical supervision. The formative element of clinical supervision is reported as an important part of nurses' continuous professional development as it supports lifelong learning (Wood, 2004). In a thematic review, Hyrkas and Paunomen-Ilmonen (2001) suggest that nurses reported that personal (my) knowledge, shared (our) knowledge and theoretical knowledge increased as a result of clinical supervision. Nurses also reported better problem-solving (Žorga, 2002). Students have reported that clinical supervision enables them to better incorporate theory and practice (Aston and Molassiotis, 2003; Landmark et al., 2004). Nurses and students were also more able to verbalise their knowledge (Arvidsson et al., 2001; Aston and Molassiotis, 2003). Through his own experience as a supervisor, Jones (2003) suggests that clinical supervision can potentially improve practice through increased understanding, problem-solving and emotional support of nurses.

Other qualitative evidence supports this argument. Hyrkas and Paunomen-Ilmonen (2001) found that nurses describe themselves as 'producers of quality' associated with being a satisfied worker. Nurses also feel it enhances the caring process and improves job efficiency (Willson et al., 2001; Jones, 2003). Several qualitative studies cited examples of changes to current practice as a result of clinical supervision (Cheater and Hale, 2001; Willson et al., 2001; Marrow et al., 2002). Furthermore many nurses report they become more ethically sensitive (Severinsson, 2001). For example they reported being more aware of their professional responsibility (Jones, 2003) and described a renewed respect for the patient and better sensitivity to patient dignity (Hansebo and Kihlgren, 2004).

Arvidsson et al. (2001) suggest that the benefits of clinical supervision may continue when supervision is terminated. They evaluated 10 psychiatric nurses' perceptions of a two year group clinical supervision project. After a four year period, the benefits expressed were similar to those that had been collected immediately following project closure.

Senior nurses also felt the benefits of regular clinical supervision. Two studies, Hyrkäs et al. (2005) and Hyrkäs et al. (2003) concentrated on Nurse Manager perceptions of clinical supervision. Each nurse manager participated in peer supervision for 2 hour each month. In the latter study there was a substantial drop-out rate. Interviews, essays and empathy based stories were analysed to determine major themes. In these studies, ben-

efits included personal growth, increased self-esteem, self-awareness and coping.

Supervisors also feel that they benefit from providing clinical supervision, suggesting that it improves their own practice. Focus groups suggest that providing clinical supervision encouraged nurses to ensure they were up-to-date with the latest practices and techniques (Landmark et al., 2003). Hyrkäs (2005) survey using the standardised instruments: the Manchester Clinical Supervision Scale, the MBI and Minnesota Job Satisfaction Scale, found that supervisors had greater job satisfaction and improved scores on de-personalisation and personal accomplishment subscale measurements. In a questionnaire evaluating a student peer supervision scheme, Aston and Molassiotis (2003) found that senior students who provide clinical supervision for junior students found it helpful and felt it increased their confidence and encouraged reflective practice.

Supervisors suggest that it is important to have adequate training and their own clinical supervision to ensure that supervisees gain maximum benefit from the experience (Willson et al., 2001). Severinsson (2001) suggests that adequate supervisory skills are vital because of moral responsibilities, and knowledge and skills transfer between supervisors and supervisees. Furthermore supervisors may influence supervisee behaviour, which in turn could influence the care of patients. Hyrkäs (2005) found that higher quality supervision was associated with decreased burnout, whilst inefficient supervision correlated with increased dissatisfaction. Many felt anxious about the responsibilities of supervision and doubted their ability to fulfil their role, particularly if the supervisor has recently qualified (Landmark et al., 2003). Some studies have suggested that supervising nurses can be anxiety provoking, threatening and require a profound knowledge of current literature (Landmark et al., 2003).

Some studies suggest that reflective skills need to be learned and practiced as part of supervisory skill development (Willson et al., 2001; Lähteenmäki, 2005). Clavierole and Mathers (2003) describe how nurse lecturers engaged in clinical supervision in order to improve their ability to provide supervision for students.

Ethical debate, personal and organisational challenges

There is an ongoing debate in the literature about the ethical dilemmas produced by clinical supervision. Several authors have argued that part of the function of clinical supervision is to improve practice and create a workforce that is aware of ethical dilemmas. Reflection, it is suggested, leads to ethical decision-making based on three core themes: 'Is it safe?' and taking into account rules, codes and values, 'Is it right?' and 'Is it kind?'. Berggren et al. (2005) suggest that clinical supervision ''*enables supervisees to reflect on ethically difficult caring situations thereby strengthening their professional identity, integrating nursing theory and practice and leading to the development of ethical competence*'' (p. 21). After the introduction of clinical supervision, in a Likert scale questionnaire, Magnusson et al. (2002) found that those being supervised trusted their ability to interpret clients' emotions and behaviours more than those who had chosen not to undertake supervision. They were also more aware of respecting privacy and autonomy and were more willing to encourage patient-led decision-making. Olofsson's (2005) study of the effectiveness of clinical supervision in relation to coercive incidents had mixed results. Three psychiatric wards met for clinical supervision regarding coercion. Originally group supervision was to be held within a week of a coercion incident, but due to difficulty in organising this, small group supervision was scheduled for 1.5—2 h every two weeks, totalling 11 sessions over eight months. Composition of groups were dependant upon the availability of staff member and the author notes resistance from participating staff. Twenty-one out of twenty-three nurses who participated were interviewed. Whilst most nurses found discussing incidents of coercion helpful, a minority felt that the clinical supervision sessions were not useful as they were not concurrent to the event. Some felt that clinical supervision was not useful because they felt that the use of coercion was a necessary part of the job and therefore did not represent a difficult situation. It is possible that those who most need clinical supervision may be less likely to engage in it and find it useful. A number of other studies have highlighted similar issues (Freshwater et al., 2002; Winstanley and White, 2003). This has implications in terms of non-disclosure of serious incidents or shortcomings. Gilbert (2001) suggested that clinical supervision can be an intentional form of social control and surveillance. Through reflection, it is suggested, clinical supervision enables a set of 'morally superior values' to be adopted. Caring professions can then act as a 'judges of normality' and exercise their influence to control what they deem 'risky' behaviours. Clinical supervision helps to socialise nurses in these 'morally superior values' as well as control them by inciting nurses to reveal the truth about their practice including any

difficulties. Johns' (2001) findings that observation of manager supervisors during supervision, they tend to be authoritative despite advocating an emancipating interest during interviews, may support this proposal. Somewhat differently, Clouder and Sellars (2004) argue that this may be naive as it portrays nurses as being passively submissive to controlling influences. They argue that nurses have the ability to conceal the truth if they wish. They also point out that most studies have reported clinical supervision as a positive experience and that nurses do not report feeling controlled. Indeed in a survey of students perception of clinical supervision as they progress through their course, Landmark et al. (2004) argued that clinical supervision actually allowed students to challenge prevailing orthodoxy.

Overall there is little evidence that clinical supervision is a negative experience, however some studies suggest that clinical supervision does not always produce universally positive results. After one year of monthly 1 h individual clinical supervision session, some nurses felt they could not identify any concrete benefit from clinical supervision (Willson et al., 2001) and some studies have reported that participants have questioned its value (Hyrkas et al., 2002; Deery, 2005). In some studies there are significant drop-out rates. Hyrkäs et al. (2003) reported that three out of five hospitals in their study terminated supervision early, two made this decision as they did not feel they were benefiting from clinical supervision. In an action research study, Deery (2005) described their supervisees as resistant, attendance being poor and 'participant drop-out' when they tried to introduce clinical supervision to midwives.

Resistance by nurses to the uptake of supervision could be due to a number of reasons. A minority of nurses felt that participating in clinical supervision would increase their stress levels (Hyrkas et al., 2002). Some felt that clinical supervision might be an anxiety provoking experience as it meant admitting to difficulties (Jones, 2001, 2003; Johns, 2003). Many were unsure about confidentiality issues and how information would be used (Turner et al., 2005). This could lead to some nurses feeling threatened and being reluctant to undertake clinical supervision (Jones, 2001).

Cottrell (2002) described four types of resistance to supervision: tokenism, resistance, mutiny and suspicion. Some suggest that the theoretical virtues of clinical supervision do not translate into practice because nurses do not practice clinical supervision as it was conceptualised. Hughes (2005) suggested that like many CPD activities, clinical supervision can be seen as a 'paper exercise'. Some studies have suggested that clinical supervision was also used as a forum to air grievances rather than to reflect constructively (Hyrkas et al., 2002; Johns, 2003). Conversely other studies found clinical supervision too supportive, confirming group membership at the expense of examining practice (Walsh et al., 2003; Hughes, 2005). Finally, even if nurses participate in critically reflective clinical supervision benefits may remain minimal. Some authors have found that the organisation does not always provide adequate support for clinical supervision. For example, managers in Freshwater and colleagues' survey (2002) felt that clinical supervision would not be in place after the study period was finished despite achieving positive results.

Effects on patient outcome and staffing disposition

It is suggested that ''*The impact that clinical supervision has on patient outcome is one that tantalisingly remains out of reach*'' (Carson, 2007). This is true and reported research and development in this area is limited, however important moves are being made to test effects on patients and clinical outcomes. These may be progressed in three ways: (i) by recording clinical interventions that are seen to improve patient care, (ii) by measured change to patient outcome and (iii) as part of measured effects on patients affected by staffing and 'failure to rescue' studies. Three examples serve to illustrate the case.

Some studies suggest that clinical supervision can be cost effective and improve patient care. Hyrkäs et al. (2001) examined the cost effectiveness of team supervision over three years in a hospital in Sweden. Costs included nurse time and cost of the supervisor. The benefits measured were: (1) greater knowledge as measured through increased training expenditure as it was expected that clinical supervision would help identify training needs, (2) increased patient care as measured by improved patient satisfaction and a decrease in complaints and indemnities registered and (3) a decrease in stress as measured by a reduction in sick days. They found that the overall cost for clinical supervision was low and cost effective. Sick days decreased and the number of patients treated increased, arguably due to better quality and efficient patient care.

Hansebo and Kihlgren (2004) introduced clinical supervision for 2 h a month in a nursing home. Analysis of nursing documentation, patient life stories

as told by carers, video footage of morning care sessions and questionnaires showed that after receiving clinical supervision, carers in a nursing home showed improved quality of verbal and written communication. As the amount of notes taken increased, they were more able to verbalise their reflections, and accounts became more complete and patient-focused. Furthermore, in video footage of daily care, routine carers displayed more competence and were more aware of maintaining patients' dignity.

A quasi-experimental pilot study, Bradshaw et al. (2007), was established to assess whether clinical supervision provided by work placed supervisors could enhance outcomes for study programme attendees and the service users they worked with. They found that the severity of positive symptoms of patients suffering from schizophrenia decreased significantly more in a cohort being treated by current students who received clinical supervision during their studies compared to a group that had been treated by previous students that did not have supervision as part of their course. The latter group of students also had a better understanding of psychosocial interventions and schizophrenia. This interesting area will benefit from further and larger studies and some are being established at the time of writing this paper (Queensland Treasury, 2006).

Significant advances have been made in demonstrating the effects on patient outcome of nurse staffing levels, indeed, it is possible to now show effects on patient well-being, recovery and mortality (West et al., 2006). Part of the supporting evidence for this work and the positive or negative effects of nurses on patient outcomes is related to in particular strong nursing professional leadership (McGill-Hall, 2002) potential for burnout (Mark, 2004), enhanced educational opportunity and length of experience (Tourangeau et al., 2002). As the literature in this review demonstrates, this is familiar territory for clinical supervision and appears to be a fruitful area for further research work, most particularly in episodes of 'failure to rescue' so well articulated by Aiken and her colleagues (2002).

Commentary

The thematic areas explored in this review offer interest. Some work clearly shows professional self-interest, others raise questions of application and implementation. There are some rather 'tired' discussions offering no new insights but encouragingly, new ideas relating to patient outcome and

professional development are emerging. Employer organisations are beginning to be identified as critically influential.

Levels of engagement carry a number of confounding factors. They are likely to be determined by organisational culture, availability of time, supervisor numbers and a host of other local factors. Few significant conclusions can be drawn from the reported data but organisational culture is consistently reported as an important determinant of implementation. In England (Burdett Trust, 2006), an agenda item content analysis of Health Care Trust board meetings showed that less than 14% of agenda items directly related to matters of clinical concern. Clearly, the capacity or willingness of some health care organisations to attend to clinical matters is concerning.

Clinical supervision as a supportive device has attracted more attention than any other. Most studies are self-reported, qualitative in method and suggest that clinical supervision and its processes confer benefit in many ways. It is not possible to attribute all these positive effects merely to clinical supervision. However, it is quite proper to suggest that structured opportunities to discuss case related practice, personal and educational development are vital to nurses, their practice and patient safety. At a time when such opportunities are being stripped from the working week and seen by some employers as unproductive, evidence seen here suggests entirely the opposite and strongly counters the prevailing view of this being 'unproductive' time. Employees who are supported and are allowed time to reflect and develop will make a significant contribution to patient well being and safety and employers bear a considerable responsibility in sustaining and developing this activity in their organisations. Literature giving accounts of ethical debates and the personal and organisational challenges for participants is interesting. There are those who declare the process to be a sinister imposition and others who see its properties to be almost akin to a 'magic bullet'. It is neither of course, but questions raised in the literature are right and proper. Discussions on tokenism and badly practised clinical supervision hold necessary lessons. There is evidence for the strength of clinical supervision but it is clear that it makes some clinicians uncomfortable.

It is most encouraging that it is now possible to articulate three potential work streams in patient outcome and staffing. The outcomes of further work in this area may lie in improved patient safety, professional development and accountability and enhanced clinical outcome. All are very worthy subjects for investigation.

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