

(UNEDITED) APPENDIX 16: CLINICAL SUPERVISION by John Driscoll

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The supervision of students by qualified nurses is a common event in clinical practice. However, the continued supervision of nurses once qualified, is not so usual unless participating in a formalised course of study. It is an interesting situation that for three years prior to qualifying as a nurse, you are entitled to be given the necessary education and support to become an accountable practitioner in practice. Yet once qualified and accountable, inside the complex world of clinical practice, formalised supervision disappears after some rudimentary preparation period.

In other health related disciplines such as counselling and psychotherapy, midwifery, and social work, regular feedback on clinical practice for qualified practitioners is not an unusual feature of practice. Not surprisingly, the nursing literature on the development of clinical supervision, has become interested in disciplines who regularly talk to each other about practice, in practice.

The need to formalise talking to one another during worktime in order to learn, as well as support each other in practice, is legitimised by the Chief Nursing Officers of the UK. *A Vision for the Future* (Department of Health 1993) sought to provide a blueprint for nursing, midwifery and health visiting activities into the new millennium. It emphasised the development of clinical supervision as a key target for registered nurses to maintain clinical competence and become more personally responsible in practice. Some of these ideas have now been given an added impetus with a demand to modernise the NHS (DOH 1998a,1998b) and the expected nursing, midwifery and health visiting contribution in enhancing the quality of UK healthcare provision (DOH 1999).

From the many textbook ideas about what clinical supervision is, a number of key themes emerge;

- a formal (contractual) process of professional support and learning
- practitioners assuming responsibility for practice
- a way of enabling practitioners to share and learn from experience
- a way of enhancing consumer protection and safety of care
- a formal arrangement enabling nurses to discuss their work at work
- sustaining and developing professional practice
- the development of professional skills and competence
- formalised reflective practice in practice
- contributing to quality patient services

(Driscoll 2000)

Bishop (1998) in helping practitioners implement clinical supervision, offers a useful definition for clinical practice that encompasses many of the previous ideas;

Clinical supervision is a designated interaction between two or more practitioners, within a safe /supportive environment, which enables a continuum of reflective, critical analysis of care, to ensure quality patient services.

Whilst clinical supervision might be a new concept to many practitioners, the three main components of it are already happening in everyday practice;

- supervised clinical practice and learning
- organisational supervision
- supportive supervision

Supervised clinical practice and learning

This type of supervision is well known to practitioners. Both parties in this form of clinical supervision relationship operate in well defined roles in which success is identified in the form of learning outcomes. The supervisory role in this type of supervision is usually one of assessor

or mentor. This is achieved by giving regular feedback on the students ability to meet designated learning outcomes and making judgements about the learners' clinical competence.

Organisational supervision

Not unlike supervised practice, organisational or managerial supervision focuses on employee performance in the healthcare setting e.g. risk management, maintaining quality care, operationalising human resources, financial planning or associated activities and can either be formal or informal. Perhaps it is not surprising that the introduction of badly thought out clinical 'supervision' in practice can evoke suspicion, or feelings by practitioners of being 'watched' or 'controlled' in some way by those responsible for the overall management of service delivery. But the UKCC (1996) unequivocally states that clinical supervision is not;

- the exercise of overt managerial responsibility or managerial supervision
- a system of formal individual performance review or,
- hierarchical in nature

The more traditional aims and goals of management supervision as being a formal, monitoring process that insists on good practice, differs from clinical supervision that is a more enabling process, intended to support effective practice.

Supportive supervision

Support systems have always been a feature of nursing practice. Some emerge from working and knowing that you can trust a particular person(s), that they will not laugh at you, or are prepared to listen to your practice concerns. Butterworth et.al (1998) describe these well known ad- hoc and unplanned forms of supportive supervision as 'tear breaks', in which caring for one forms an important way of surviving the business of caring for others. Clinical supervision is not intended to replace such episodes in practice, but is an additional source of formalised help available to all practitioners.

The need to formalise clinical supervision is to ensure that it becomes a legitimate part of everyday practice. Whether one to one, or group sessions, the participants negotiate and agree a written contract together which identifies ground rules about the supervision process to be

undertaken. One of the fundamental differences between clinical supervision and other supervision already happening, is the adoption of '*the qualified nurse also as a lifelong learner in practice*' concept. This can be extremely challenging where the previous norms of supervision in practice have tended to be more hierarchical in nature. Therefore the sorts of issues to consider in any clinical supervision contract are likely to be;

- the purpose of clinical supervision and knowing what it is not
- obtaining agreement on how often sessions will occur and be organised
- how participants will know if clinical supervision is working or not

The functions of clinical supervision in social work practice, have also formed the basis of supervisory functions within much of the UK nursing literature on clinical supervision. Brigid Proctor's (1986) Interactive Model of Clinical Supervision describes three supervisory components that are not dissimilar to those previously described, that of supervised practice, organisational supervision and supportive supervision.

- normative (managerial/organisational function)
- formative (learning/educational function)
- restorative (supportive function)

Being aware of the different functions and possibilities of supervision is not only useful for the clinical supervisor in structuring or using as a criteria for supervision, but also for the supervisee to maximise the use of the session time available (Driscoll 1999). The three functions can also remind practitioners of the different 'supervisory hats' or approaches, from the more traditional supervision activities in practice outlined previously. Proctor's (1986) supervisory components have also formed the basis for evidencing clinical supervision outcomes in UK nursing (Bowles & Young 1999, Rafferty et. al 1998)

For clinical supervision to be sustained in clinical practice against all the other demands for practitioners' time, its effectiveness needs to be evaluated. For the most part, UK health employers have invested in clinical supervision largely on assumptions that it will be advantageous in clinical practice and will therefore need to be convinced that further

investment is warranted. Research is now beginning to surface about the benefits and outcomes of implementing clinical supervision in practice (Butterworth et. al. 1997, WMCSLS 1998).

Breaking down clinical supervision into its different component parts is easier than thinking of the whole of clinical supervision and how it can be monitored for its effectiveness. One of the obvious things to do is to keep some record, or documentation, of what happens in clinical supervision rather than having to remember something about it when asked. Any monitoring of the effectiveness of clinical supervision should ideally rest with the supervisee's personal experience of clinical supervision, as it is they who understand what effective and ineffective clinical supervision really is. This means taking into account qualitative, not just quantitative research methods. Butterworth & Bishop (1994: 42-44) suggest it is possible to audit clinical supervision through existing reporting mechanisms such as;

- clinical audit
- rates of sickness and absence
- staff satisfaction scales
- numbers of patients' complaints
- retention and recruitment of staff
- critical incident maps
- stress and burnout assessment tools
- staff health questionnaires
- trust-wide educational audit
- individual performance review
- live supervision recorded on video or audio tape
- *post hoc* analysis of audio or video tape recordings
- *live* or *post hoc* analysis of supervision observation notes

Clinical supervision in addition to more traditional forms of supervision in UK practice offers many possibilities for nurse practitioners, the organisations in which they work and most importantly, the persons that are cared for and has slowly evolved throughout the 1990's. Whilst the work ethic of clinical practice continues, from within modern healthcare is emerging a genuine concern for the personal health of the workforce that are increasingly faced with

more complex practice challenges. Clinical supervision is about caring for oneself enough to continue to deliver effective care for others. The vehicle of clinical supervision is formalised reflective practice in practice for already qualified practitioners. Accepting the importance of being able to formally stop, and intentionally reflect with others about practice, in practice and putting back that learning for the benefit of others, is a fundamental principle of the re-modernisation of state run healthcare provision in the UK.

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