Clinical Supervision Background Paper

Clinical Supervision (CS) is a formally structured arrangement between a supervisor and one or more supervisees purposely constructed to provide a space for critical reflection on the work issues brought to that space by the supervisee(s). The broad aim of CS is to facilitate the professional development of the supervisee(s) through increased awareness and understanding of the complex human issues within their workplace.

CS has an established history in the health care professions including psychotherapy, counselling, social work, psychology and psychiatry (Yegdich & Cushing 1998). It was reflected in the North American and Scandinavian nursing literature as early as the 1970s (Yegdich & Cushing 1998) and is a regular focus of discourse in relation to mental health nursing (Dilworth et al. 2013, Wright 2012, Brunero & Stein-Parbury, 2008, Butterworth et al. 2008, Turner & Hill 2011, Buus & Gonge 2009, Cummins, 2009). In addition, CS is of interest in the general nursing (Govoni 1997, von Klitzing 1999, Hyrkäs et al. 2003, Bailey & Graham 2007, Cross et al. 2010, Cross et al. 2012, Koivu et al. 2012, Brunero & Lamont, 2012, Dawber 2013a, Dawber 2013b, Dawber & O'Brien 2013, Fowler 2013a, Fowler 2013b, Sharrock et al. 2013) and midwifery contexts (Lennox et al. 2008, Barnes et al. 2013, Lavery et al. 2016).

CS for all professions is now commonly referenced in Australian mental health policy frameworks (Commonwealth of Australia 2009, South Australia Health 2010, Department of Human Services 2014) with a number of jurisdictions producing their own guidelines (New South Wales Health 2006, Queensland Health 2009, Bouverie Centre 2011, Health Education & Training Institute 2013), and the establishment of interest groups and associations (Australasian Association of Supervision 2016, Australian Clinical Supervision Association 2016, Australian College of Mental Health Nurses Clinical Supervision Special Interest Group 2016).

CS is usually conducted either in dyads (one-to-one), or in small groups of 6-8 supervisees. Because CS originated in psychotherapy and counselling training, the focus of CS has

traditionally been on the clinician consumer relationship. Material from that relationship is brought to the formal CS meeting and discussed in a retrospective and reflective way. Through the development of a trusting professional alliance, the supervisee can explore the helping role and all the uncertainty it carries. Within this framework, the aim of CS is to maximise the supervisee's ability to provide therapeutic support to the consumer through:

- understanding the consumer;
- understanding the emotional, cognitive and behavioural reactions of the consumer as well as the supervisee;
- understanding the relationship between the supervisee and consumer;
- maximising the psychotherapeutic potential with the consumer and;
- learning from linking theory and practice.

In addition, the supervisee may explore professional issues that require deeper reflection to understand. Through reflection on practice, CS provides the supervisee with the opportunity to develop reflective skills more generally, which Benner (1984) proposed as essential to advanced practice. The supervisee learns not only to reflect *on* practice but also to reflect *in* practice (Freshwater 2008) and *before* practice (Heath & Freshwater, 2000). It has been argued that the ability to reflect can result in 'more carefully chosen interventions in the moment and decrease the risk of being reactive or impulsive' (Sharrock et al. 2013), to practice *mindfully* (Rolfe 1997), or with *intentionality* (Freshwater 2008), which all increase the likelihood of helpful interventions.

Models of Clinical Supervision provision

Operational definitions of CS, preferred models of practice, frameworks for implementation and strategies for systematic evaluation vary within and between professional groups and practice settings (Buus & Gonge 2009, Wright 2012, Sloan & Grant 2012). Dilworth et al. (2013) suggest that "…the complexity and confusion within the literature is generated by the diverse expectations and outcomes of clinical supervision".

However, the Proctor Model (1986) of CS has become one of the most influential and widely adopted models in nursing contexts (White & Winstanley 2011). It comprises three domains:

- Normative: to address the promotion of standards and professional accountability
- Restorative: to support the wellbeing of the supervisee
- Formative: the educative component that develop knowledge and clinical skills

In the literature review undertaken by Bunero and Stein-Parbury (2008), the reported outcomes from 22 studies into the effectiveness of CS were categorised according to Proctor's domains. This paper provides a useful summary of the proposed benefits of CS. The authors concluded that in the studies that they reviewed, the restorative function was reported more frequently. White and Winstanley (2010) demonstrated that effects of CS appear to act on the three domains at different speeds; changes in the normative and restorative are likely to precede measurable changes in the formative. Importantly, therefore, this implies that the benefits to consumers/patients may be demonstrated *subsequent* to the successful establishment of an organisational culture, in which staff well-being and attention to continuous clinical audit have been promoted through sound CS.

CS is conceptually distinguished from case review, performance review and management and managerial line reporting. Although, CS is a helping relationship and therefore has similarities to psychotherapy and counselling, it is also distinguished from personal therapies in that it is not directed toward the personal growth and development of an individual but on professional skill development. Personal growth occurs as a *by-product* of CS (Sharrock et al. 2013) as opposed to being the goal of CS. It is important to note that it is the responsibility of the supervisor to maintain the structure, boundaries and focus of CS as the supervisory relationship develops (Lynch et al. 2008).

Evidence for Clinical Supervision:

There is growing evidence that a formally established alliance between practitioners, in which the roles of supervisor and supervisee(s) are clearly defined and that is focused on professional support through facilitated reflection, is likely to have positive outcomes for

the supervisees (Brunero & Stein-Parbury 2008). These have variously related to the restorative functions (e.g. personal development, improved coping and wellbeing, confidence, reduced emotional strain and burnout, staff morale, sick leave and retention), normative functions (e.g. professional identity and satisfaction, critiquing practice, moral sensitivity and confirmation of actions and role) and formative functions (e.g. increased knowledge and awareness of possible solutions to clinical issues, greater reflection on practice, professional growth, self-awareness of thoughts and feelings, improved communication skills and confirmation of consumer uniqueness). Supervisees report a perceived improvement in their ability to provide clinical care to consumers (Brunero & Stein-Parbury 2008) which is supported by more recent studies (Bambling et al. 2006, Bradshaw et al. 2007, Buus & Gonge 2009, Winstanley & White 2010).

While the positive impact of CS is repeatedly reported and there is an overall commitment to CS for those working in the helping professions, there are cautions and concerns about the promotion of CS. Whilst CS may help to achieve the best level of care possible, Bishop (1994) asserted that it cannot compensate for inadequate facilities, for poor management, or for unmotivated staff (White & Winstanley 2009b). In addition, good supervisors are as unlikely to have a desired effect in unhealthy cultures, as are poor supervisors in healthy cultures (White & Winstanley 2010). Risks that have been associated with CS and reflective learning include unintended disclosure of personal information, breaches of confidentiality and bullying (Yip 2006, Butterworth et al 2008,).

Limitations regarding the strength of the evidence have been identified and '…there is a need to address methodological limitations in order to improve the strength of the evidence' (Dilworth et al. 2013). This is a challenge given robust, outcome-related CS research is difficult to design, conduct, interpret and fund (White & Winstanley 2011). Further small and large scale outcomes-related studies in a variety of settings are necessary to test emerging theoretical propositions using relevant instruments that have well established and publicly reported psychometric properties.

Implementation of Clinical Supervision:

Despite the interest in CS within nursing, there have been significant challenges for the implementation of integrated systems for CS (Lynch & Happell 2008a, Lynch & Happell 2008b, Lynch & Happell 2008c). Concerted effort is still required to ensure that CS is better understood, accepted and practiced in Australia (Taylor & Harrison 2010) and convincing programs of CS education (White & Winstanley 2009a) and outcomes-related research remain necessary to further substantiate the claims made for CS (White & Winstanley 2011).

It has also been shown that any effect CS may have is likely mediated by the training that supervisors receive, the quality of the supervision they provide, the culture in which the CS endeavour is located and, in particular, the attitude of managerial staff. However, in settings where each of these mediating factors was not an impediment, White & Winstanley (2010) also found incremental evidence toward a positive causal relationship with quality of care and patient outcomes.

In order that CS may be successfully implemented and sustained, the best and clearest directions currently available White & Winstanley (2010) suggests that a number of environmental conditions should be met:

1. CS should be universally considered part of the core business of contemporary professional nursing practice.
2. Positive support for CS should be evident at all levels of service management and accepted as a dominant feature of the organisational culture.
3. The mainstream status of CS should be written into all workforce policies, as a positive expectation for all staff to engage.
4. Explicit protocols should be in place to confirm the arrangements necessary for the sustainable implementation across all services (size, 1:1 or 6-8 in groups; frequency, not less than monthly; duration, not less than 60 minutes; ground rules about confidentiality and so on), together with a dedicated information management system to continuously monitor these are given full effect.
5. Supervisees should retain the option to choose their own Clinical Supervisor. This should be an appropriately trained and experienced practitioner, who does not hold operational or managerial responsibility for the Supervisee.

6. Individuals identified by local criteria to become Supervisors should be appropriately educationally prepared for their role, to an efficacious standard.
7. Upon appointment, *all* staff should be assisted to become fully orientated to local CS arrangements, including new graduates and others transferring into the health workforce.
8. Service managers who hold individual responsibility for the staff roster and budget should to be provided with the support necessary to ensure a smooth CS operation, without deleterious effect on clinical contact time (akin to exiting arrangements for staff handover meetings).
9. Programs of continuous evaluation in discrete clinical locations should be in place to ensure that the quality and efficacy of local CS arrangements are able to be demonstrated and regularly reported.
10. Suitable administrative records should be maintained (a suggested CS Agreement template is available from the ACMHN website).

References:

Australasian Association of Supervision (AAOS) 2016, Australasian Association of Clinical Supervision, viewed 25 March 2016, < http://www.supervision.org.au/>

Australian Clinical Supervision Association (ACSA) 2016, Clinical Supervision, viewed 25 March 2016, <http://clinicalsupervision.org.au/>

Australian College of Mental Health Nurses (ACMHN) 2016, Clinical Supervision Special Interest Group, viewed 25 March 2016 <http://www.acmhn.org/index.php/home-cssig 25 March 2016>

Australian College of Mental Health Nurses (ACMHN) 2013, *Scope of Practice 2013 and Standards of Practice 2010.* ACMHN, Canberra.

Bailey M & Graham M 2007, Introducing guided group reflective practice in an Irish palliative care unit, *International Journal of Palliative Nursing,* vol 13**,** pp. 555-560.

Bambling M, King R, Patrick R, Schweitzer R & Lambert W 2006, Clinical supervision: its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression, *Psychotherapy Research*, vol 16 (3), pp. 317–331.

Barnes M, White E, Winstanley J & Reed R 2013, Clinical supervision and continuing professional development for midwives in Queensland, Australia: Findings from an online survey, *Focus on Health Professional Education,* vol 14**,** pp.1.

Benner P 1984, *From novice to expert: excellence and power in clinical nursing practice*. Menlo Park, Ca: Addison-Wesley Publishing Company

Bishop V 2008, Clinical governance and clinical supervision: protecting standards of care. (Editorial), *Journal of Research in Nursing*, vol 13 (1), pp.3–5.

Bouverie Centre 2011, Clinical Supervision Guidelines, viewed 25 March

<http://www.clinicalsupervisionguidelines.com.au/>

Bradshaw T, Butterworth A & Mairs H 2007, Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with?, *Journal of Psychiatric and Mental Health Nursing*, vol 14 (1), pp. 4–12.

Brunero S & Lamont S 2012, The process, logistics and challenges of implementing clinical supervision in a generalist tertiary referral hospital. *Scandinavian Journal Of Caring Sciences,* vol. 26**,** pp.186-193.

Brunero S & Stein-Parbury J 2008, The effectiveness of clinical supervision in nursing: an evidenced based literature review, *Australian Journal of Advanced Nursing,* vol. 25**,** pp. 86-94.

Butterworth T, Bell L, Jackson C & Pajnkihar M 2008, Wicked spell or magic bullet? A review of the clinical supervision literature 2001–2007, *Nurse Education Today*, vol.28 (3), pp. 264-272.

Buus N & Gonge H 2009, Empirical studies of clinical supervision in psychiatric nursing: a systematic literature review and methodological critique, *International Journal of Mental Health Nursing,* vol. 18**,** pp. 250-264.

Caine M & Jackson W 2011, Clinical supervision and the theory-practice gap: view from a student mental health nurse, *Mental Health Nursing,* vol. 31 (6), pp. 9-11.

Cleary , Horsfall J & Happell B 2010, Establishing Clinical Supervision in Acute Mental Health Inpatient Units: Acknowledging the Challenges. *Issues in Mental Health Nursing,* vol. 31(8), pp. 525-531.

Commonwealth of Australia 2009, Fourth National Mental Health Plan: an agenda for Collaborative government action in mental health 2009–2014, Australian Government,

Canberra.

Cookson J, Sloan G, Dafters R & Jahoda A 2014, Provision of clinical supervision for staff working in mental health services, *Mental Health Practice,* vol. 17(7), pp.29-34.

Cross W, Moore A & Ockerby S 2010, Clinical supervision of general nurses in a busy medical ward of a teaching hospital, *Contemporary Nurse: A Journal for the Australian Nursing Profession,* vol. 35**,** pp. 245-253.

Cross W, Moore A, Sampson T, Kitch C, & Ockerby C 2012, Implementing clinical supervision for ICU Outreach Nurses: A case study of their journey, *Australian Critical Care,* vol. 25**,** pp. 263-270.

Cummins A 2009, Clinical supervision: the way forward? A review of the literature. *Nurse Education in Practice,* 9**,** 215-220 6p.

Dawber C & O'Brien T 2013, A Longitudinal, Comparative Evaluation of Reflective Practice Groups for Nurses Working in Intensive Care and Oncology, *Journal of Nursing Care,* vol. 2**,** pp.1-8.

Dawber, C 2013a, Reflective practice groups for nurses: a consultation liaison psychiatry nursing initiative: part 1-The model. *International Journal of Mental Health Nursing,* vol. 22**,** pp.135-144.

Dawber C 2013b, Reflective practice groups for nurses: a consultation liaison psychiatry nursing initiative: part 2-the evaluation, *International Journal of Mental Health Nursing,* vol. 22**,** 241-248.

Department of Health 2014, Victoria's specialist mental health workforce framework Strategic directions 2014–24, Victorian Government, Melbourne.

Dilworth S, Higgins I, Parker V, Kelly B, & Turner J 2013, Finding a way forward: A literature review on the current debates around clinical supervision, *Contemporary Nurse,* vol. 45(1), pp. 22-32.

Fowler, J 2013a, Advancing practice: from staff nurse to nurse consultant Part 4: using clinical supervision, *British Journal of Nursing,* vol. 22**,** pp.941-941.

Fowler J 2013b, Advancing practice: from staff nurse to nurse consultant. Part 3: the NMC Perspective, *British Journal of Nursing,* vol. 22**,** pp.904.

Freshwater D 2008, Reflective practice: the state of the art, In D. Freshwater, B. Taylor, & G. Sherwood (Eds.), *International textbook of reflective practice in nursing* (pp.1-18), Oxford: Wiley-Blackwell.

Gonge H & Buus N 2011, Model for investigating the benefits of clinical supervision in psychiatric nursing: A survey study, *International Journal of Mental Health Nursing* vol 20, pp. 102 – 111.

Gonge H & Buus N 2015, Is it possible to strengthen psychiatric nursing staff's clinical supervision? RCT of a meta-supervision intervention, *Journal of Advanced Nursing,* vol. 71(4), pp. 909-921.

Govoni A 1997, Development and implementation of nursing consultation groups on a spinal cord injury unit. *SCI Nursing: A Publication of the American Association of Spinal Cord Injury Nurses,* vol. 14**,** pp.3-7.

Heath H & Freshwater D 2000, Clinical supervision as an emancipatory process: avoiding inappropriate intent, *Journal of Advanced Nursing,* vol. 32(5), pp. 1298-1306.

Health Education & Training Institute (HETI) 2013, *The Superguide:* A Supervision Continuum For Nurses and Midwives, HETI, Sydney.

Hyrkäs, K, Koivula M, Lehti K & Paunonen-Ilmonen M 2003, Nurse managers' conceptions of quality management as promoted by peer supervision, *Journal of Nursing Management,* vol. 11**,** pp. 48-58.

Koivu A. Saarinen P & Hyrkas K 2012, Does clinical supervision promote medical-surgical nurses' well-being at work? A quasi-experimental 4-year follow-up study, *Journal of Nursing Management,* vol. 20**,** pp. 401-413

Lavery J, Wolfe M & Darra S 2016, Exploring the value of group supervision in midwifery: Part 1. *British Journal of Midwifery,* vol. 24**,** pp.196-202.

Lennox S, Skinner J & Foureur M 2008, Mentorship, preceptorship, and clinical supervision: three key processes for supporting midwives, *New Zealand College of Midwives Journal,* vol. 39**,** pp.7-12.

Lynch L & Happell B 2008a, Implementation of clinical supervision in action: part 2: implementation and beyond, *International Journal of Mental Health Nursing,* vol. 17**,** pp. 65-72.

Lynch L & Happell B 2008b, Implementation of clinical supervision in action: part 3: the development of a model. *International Journal of Mental Health Nursing,* vol. 17**,** pp. 73-82.

Lynch L, & Happel B 2008c, Implementing clinical supervision: part 1: laying the ground Wor, *International Journal of Mental Health Nursing,* vol. 17**,** pp. 57-64.
Lynch L, Hancox K, Happell B & Parker 2008, *Clinical supervision for nurses.*
Chichester, United Kingdom: Wiley-Blackwell.

NSW Health 2006, *Drug and Alcohol Clinical Supervision Guidelines*. Sydney: New South Wales Health Department. Sydney.

Proctor B 1986, Supervision: a co-operative exercise in accountability. In: Enabling and ensuring. M. Marken and M. Payne (eds). Leicester National Youth Bureau and Council for Education and Training in Youth and Community Work, Leicester, pp.21-23.

Queensland Health 2009, *Clinical Supervision Guidelines for Mental Health Services*. Mental Health Branch, Queensland Health, Brisbane.

Rolfe, G 1997, Beyond expertise: theory, practice and the reflexive practitioner, *Journal of Clinical Nursing,* vol. 6, pp. 93-97.

South Australia Health 2010, South Australia's Mental Health and Wellbeing Policy. Mental Health Policy Unit Policy and Inter-Governmental Relations, Department of Health South Australia, Adelaide.

Sharrock J, Javen L & McDonald S 2013 ,Clinical supervision for transition to advanced practice, *Perspectives in Psychiatric Care,* vol. 49**,** pp. 118-125.

Sloan G, & Grant A 2012, A rationale for a clinical supervision database for mental health nursing in the UK. Journal of Psychiatric & Mental Health Nursing, vol. 19(5), pp. 466-473.

Spence S, Wilson J, Kavanagh D, Strong J & Worrall L 2001, Clinical Supervision in four mental health professions: a review of the evidence, *Behaviour Change* vol. 18 (3), pp. 135-155.

Taylor C 2014, Boundaries in advanced nursing practice: the benefits of group Supervision, *Mental Health Practice,* vol. 17(10), 26-31

Taylor M & Harrison C 2010, Introducing clinical supervision across Western Australian public mental health services*, International Journal of Mental Health Nursing,* vol. 19, pp. 287-293.

Turner J & Hill, A 2011, Implementing clinical supervision (part 1): a review of the literature, *Mental Health Nursing,* vol. 31**,** pp.8-12.

von Klitzing W 1999, Evaluation of reflective learning in a psychodynamic group of nurses caring for terminally ill patients. *Journal of Advanced Nursing,* vol. 30**,** pp. 1213-1221.

White E & Winstanley J 2009a, Implementation of Clinical Supervision: educational preparation and subsequent diary accounts of the practicalities involved, from an Australian mental health nursing innovation, *Journal of Psychiatric and Mental Health Nursing*, vol. 16, pp. 895–903.

White E & Winstanley J 2009b, Clinical Supervision for nurses working in mental health settings in Queensland, Australia: a randomised controlled trial in progress and emerging challenges, *Journal of Research in Nursing*, vol. 14 (3), pp. 263–276.

White, E. & Winstanley, J 2010, A randomised controlled trial of clinical supervision: selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to mental health nursing practice development. *Journal of Research in Nursing,* vol. 15 (2), pp.151-167.

White E & Winstanley, J 2011, Clinical Supervision for mental health professionals: the evidence base. Commissioned for Special Edition 'Current Trends in Mental Health Services'. *Social Work and Social Sciences Review,* vol. 14 (3), pp. 73-90.

Wright J 2012, Clinical supervision: a review of the evidence base. *Nursing Standard,* vol. 27**,** pp. 44-49.

Yegdich T & Cushing A 1998, A historical perspective on clinical supervision in nursing. Australian and New Zealand Journal of Mental Health Nursing, vol. 7(1), pp. 3–24.

Yip K 2006, Self-reflection in reflective practice: A note of caution. British Journal of Social Work, vol. 36(5), 777-788.