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Title Page

Finding a way forward: A literature review on the current debates around clinical supervision

Abstract

Nursing research increasingly calls for clinical supervision to support nurses and improve nursing practice. Despite this, clinical supervision is not well established in healthcare organisations. This paper employs a critical interpretive approach to review the clinical supervision literature. The review discusses the current debates and challenges exploring possible ways of moving beyond the current criticisms and limitations in the literature.

The review concludes that despite some confusion about the quantifiable outcomes clinical supervision presents a professionally enriching activity that provides a forum for sharing of knowledge and generation of shared understandings of health care. Through this shared experience it is possible that innovative and creative approaches to health care will be born.

Keywords: nursing, clinical supervision, literature review, critical reflection, multidisciplinary team clinical supervision

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Introduction

The clinical healthcare environment is increasingly complex and changing. Health professionals contend with limited resources, workforce shortages, high demand for clinical services, along with increased acuity and complexity of patients (Health Workforce Australia, 2010). In this challenging environment it has been argued that clinical supervision may buffer the tensions around what is expected and what is achievable in relation to such issues as person-centred care, implementation of clinical practice guidelines and utilization of research in an increasingly evidence based healthcare environment (Australian Resource Centre for Healthcare Innovations, 2012(ARCHI); Butterworth, Bell, Jackson, & Pajnkihar, 2008; McCormack & McCance, 2006). Such diverse expectation of clinical supervision has led to a lack of consensus about role and benefits of clinical supervision.

This paper employs a critical interpretive approach to explore the current debates, challenges and possible ways of moving beyond the current criticisms and limitations of the clinical supervision literature. As the debate stands, there are two major themes that arise as criticisms in the literature. The first relates to the complex nature of clinical supervision as an intervention. As a result of the complexity and diversity of the contexts in which it is implemented the literature reports confusion about the role and structure of clinical supervision; a diffuse unlinked evidence base; challenges measuring the effectiveness of clinical supervision and difficulty in implementing clinical supervision in practice.

The second major theme relates to resistances that arise from within healthcare organisations. Resistance to clinical supervision is perpetuated by organisational culture within healthcare that is suspicious of change. In this context time, staffing and budgets are used as an excuse by organisational management to maintain current practices (White & Winstanley, 2009).

Attempts to establish clinical supervision in practice are being limited by the current debates. These debates have essentially overlooked the role that clinical supervision can have in strengthening teams through group critical reflection on practice. Whilst nurses and nursing research are the focus of this paper, the benefits of clinical supervision should not be limited to their applications within nursing. The confusion and conjecture about clinical supervision for nurses resonates across most healthcare disciplines (Farnan et al., 2012; MacDonald & Ellis, 2012; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001).

The authors content that if clinical supervision is to achieve patient-centred care and innovation of practice; it first needs to be legitimised as real work. This will involve genuine support from nurses, management and healthcare organisations. In looking forward the authors explore multidisciplinary clinical supervision as a potential framework for supporting practice innovation through collaboration, participation and critical engagement across health care teams. This paper will outline the potential role of supervision as a forum for learning to enhance and build interprofessional collaborative practice.

Review methods

The purpose of the review was to scope the current field, identify the main debates and existing evidence around clinical supervision with a view to develop an understanding of current practices that will inform a larger project (Dixon-Woods, Cavers, et al., 2006; Mays, Pope, & Popay, 2005). The project is a post graduate thesis that examines if and how clinical supervision may facilitate change in practice within the context of a randomised control trial designed to reduce anxiety and depression through the implementation of a psychosocial intervention for adults with cancer (Turner et al., 2011). The review questions developed iteratively as an understanding of the field was developed (Dixon-Woods, Cavers, et al.,

2006; Mays et al., 2005). In light of the wide body of literature and the limitations, that will be discussed, finding a way to move forward became a focus of the review.

A snow ball sampling method was used to locate relevant literature (Aveyard, 2010; Pawson, Greenhalgh, Harvey, & Walshe, 2005). This involved several different approaches (Dixon-Woods, Bonas, et al., 2006). Including: systematic keyword searches in PsychInfo, medline, CINAHL from inception to October 2012. Keywords included: clinical supervision, supervision, nursing supervisory, mentorship, mentorship or mentors, preceptorship, critical companion; web searched for key policy and guidelines, reference chaining, key author searches and contacting authors in the field (Dixon-Woods, Bonas, et al., 2006; Dixon-Woods, Cavers, et al., 2006). These techniques located over 1000 records, 59 of which are included within the review. The sampling strategy was purposive (Dixon-Woods, Cavers, et al., 2006) initial selections being based on papers clearly related to relevant nursing literature and then moving to identify literature to inform the emerging analysis. A critical reflexive approach to the analysis that allowed attention to the contradictions and flaws in the evidence followed methods described by Dixon-Woods et al (2006). This included “line of argument synthesis” and “refutational synthesis” in a process likened to that of primary qualitative research (Dixon-Woods, Cavers, et al., 2006, p. 5). The review will initially outline the current debates and then move to a discussion about the often overlooked aspect s of clinical supervision, reflective practice and the potential for innovating practice.

Current debates

Diverse expectations for clinical supervision

In part the complexity and confusion within the literature is generated by the diverse expectations and outcomes of clinical supervision. Clinical supervision is considered by

many as a means of supporting and educating nurses and has been employed in attempts to maintain changes in practice established by educational interventions (Heaven, Clegg, & Maguire, 2006; Mannix et al., 2006), to ensure staff and patient safety (Turner et al., 2011), to improve patient satisfaction outcomes (White & Winstanley, 2010), to increase professional dialogue (Kilcullen, 2007; White & Winstanley, 2010), to decrease burnout and/ stress (Hyrkäs, Appelqvist-Schmidlechner, & Haataja, 2006; Severinsson, 2003; Wallbank & Hatton, 2011) and to provide formal support structures and facilitate reflective practice (Botti et al., 2006; Kenny, Endacott, Botti, & Watts, 2007; Turner et al., 2007; Watts, Botti, & Hunter, 2010). There are a plethora of clinical supervision models within the nursing literature but few of them are well defined (Buus & Gonge, 2009; Fowler, 1996; Sloan, White, & Coit, 2000). Proctor's model is becoming widely utilised within the nursing research. Despite its increasing popularity, there is criticism that perhaps this model is too imprecise, failing to identify interventions appropriate to each domain (Sloan et al., 2000). The clinical supervision literature is criticized for lack of clarity related to what is provided in clinical supervision (Sloan et al., 2000; Yegdich, 1998). The lack of clarity about role and structure has led to a large body of evidence that is diffuse. As a result it lacks strength in the claims it makes for clinical supervision.

A diffuse evidence base

Despite a large body of evidence, the strength of the evidence as to the impact of clinical supervision is low (Francke & de Graaff, 2012; Hyrkas, 2005). The drawbacks of the existing body of literature relate to the fact there is a large body of research that is in many ways unrelated. The number of reviews points to a recognition of the need to draw together empirical findings to strengthen and link claims about the effectiveness of clinical supervision. All of the reviews appear to reach a similar conclusion: the evidence that clinical supervision is effective is not strong and there is a need to address methodological

limitations in order to improve the strength of the evidence (Brunero & Stein-Parbury, 2008; Butterworth et al., 2008; Buus & Gonge, 2009; Farnan et al., 2012; Francke & de Graaff, 2012; Gonsalvez & McLeod, 2008; Spence et al., 2001; Wheeler & Richards, 2007; Williamson & Dodds, 1999).

The methodological limitations include studies generally involving small, non-randomized samples, using non-validated tools and basic descriptive statistics for data collection, along with a lack of control or comparison group (Brunero & Stein-Parbury, 2008; Buus & Gonge, 2009; Wallbank & Hatton, 2011). This limits reliability, validity and the statistical power of the research. The analysis rarely takes into account confounding factors and researchers' preconceptions (Buus & Gonge, 2009; Spence et al., 2001). The use of supervisee or supervisor as the single source of data adds a potential bias in that there may be a difference between what they do and what they say they do (Heaven et al., 2006; Spence et al., 2001). Feedback from supervisees about the supervisor performance is also likely to be systematically biased due to the power differential in the relationship (Gonsalvez & McLeod, 2008). The role of researchers as supervisors may also introduce bias (Buus & Gonge, 2009).

Concerns about methodological limitations are echoed across multiple health disciplines including medicine (Farnan et al., 2012), psychology (Gonsalvez & McLeod, 2008) and allied health (Spence et al., 2001). Despite these concerns, no-one is willing to dismiss the potential benefits of supervision and programs of supervision continue to be implemented internationally and across disciplines (Alleyne & Jumaa, 2007; Brunero & Lamont, 2012; Deery, 2005; Fowler, 1996; Health Workforce Australia, 2011; Regan, 2012).

Limitations of the research have resulted in criticisms that there is uncritical acceptance that clinical supervision is good for nurses and patients (Fejes, 2008; Gilbert, 2001). Gilbert (2001) suggests that clinical supervision is reaching a point where it is

perceived as beyond question, and that this hegemony is sterilizing debate. Clinical supervision is a complex intervention. For a range of reasons it is not amenable to empiricist research designs. It may be that studies aiming to establish the effectiveness of clinical supervision on improving patient outcomes, staff performance or satisfaction are inevitably going to show limited impacts (White & Winstanley, 2010).

Complex interventions are difficult to implement and evaluate

The quantitative research reviewed often evaluated the implementation of clinical supervision interventions as either standalone projects (White & Winstanley, 2010) or through the introduction of clinical supervision alongside other changes to usual practice (BÉGat, Severinsson, & Berggren, 1997; Berg & Hallberg, 1999; Edberg, Hallberg, & Gustafson, 1996; Hart et al., 2000; Heaven et al., 2006; Kilcullen, 2007). There are several problems associated with this. Where the clinical supervision is implemented alongside other interventions the confounding nature of the dual intervention means that it is difficult to attribute the results to the influence of clinical supervision. Where clinical supervision interventions are implemented alone and then evaluated these often involve small samples that fail to show significant, generalisable change (BÉGat et al., 1997; Berg & Hallberg, 1999; Berg, Hansson, & Hallberg, 1994; Heaven et al., 2006).

Descriptions of the problems experienced as a result of implementing a new intervention are commonly discussed (Hyrkas, Appelqvist-Schmidlechner, & Paunonen-Ilmonen, 2002; White & Winstanley, 2010). These problems may be relevant to any change in practice and not specific to clinical supervision. It is suggested that follow-up periods of one year or less are not long enough to integrate the complex skills required when learning new clinical skills or approaches to care (Heaven et al., 2006; Hyrkäs et al., 2006; Kenny & Allenby, 2012). The qualitative data supports this in that there are consistent reports of difficulty implementing

clinical supervision (Jones, 2006; White & Winstanley, 2009). This is true whether supervision is implemented alone or with another intervention.

There are few randomized or control trials that examine the effects of clinical supervision on staff or patient outcomes (Berg et al., 1994; Edberg et al., 1996; Heaven et al., 2006; Mannix et al., 2006; Moorey et al., 2009; White & Winstanley, 2010). Recently, White and Winstanley's (2010) randomized control trial (RCT) showed no overall benefit to patient satisfaction, quality of care and staff wellbeing outcomes. Heaven et al. (2006) report a small randomized control trial which investigated the effect clinical supervision had on improving the transfer of knowledge from a communication training workshop into practice. The study suffered poor recruitment and high attrition (n= 57, 37.9%) limiting the applicability of the statistical analysis (Mann-Whitney U test). Contrary to this finding the work of Mannix et al. (2006) report that supportive, skill building clinical supervision was a necessary element for palliative care nurses to maintain newly learnt cognitive behavioural therapy skills and confidence in using the skills within their RCT (Moorey et al., 2009).

Survey-based studies, large and small, are used to generate a picture of what clinical supervision looks like, who is participating and what is being achieved (Hyrkas, 2005; Hyrkäs et al., 2006; White & Roche, 2006). The majority of the studies that examine the impact of clinical supervision on health, stress and burnout use cross-sectional survey data (Edwards et al., 2006; Hyrkas, 2005; Severinsson & Kamaker, 1999; Teasdale, Brocklehurst, & Thom, 2001). By its very cross-sectional design this research is not able to draw causal links between clinical supervision and outcomes. This is not a concern unique to this area. The problem calls for researchers, and research consumers to be cautious about any causal claims inferred by observational research designs.

Following these methodological and research based concerns within the literature the review will now focus on the second major theme that is more organisationally, culturally and practice based. That is, the resistance from within healthcare organisations. The authors attempt to highlight and challenge some of the taken for granted arguments within the literature (Dixon-Woods, Cavers, et al., 2006).

Resistance from within healthcare organisations

A culture resistant to change

The nature of nursing work remains task focused and routine oriented (Botti et al., 2006; Scott & Pollock, 2008; Watts et al., 2010). In relation to clinical supervision nurses describe feeling that they are not worthy of clinical supervision (Green Lister & Crisp, 2005) or that clinical supervision will be viewed as "skiving" (Stevenson, 2005). Nurses' attitudes to clinical supervision are describes as ambivalent (Brunero & Stein-Parbury, 2008; Kenny & Allenby, 2012). Clinical supervision is interpreted as not being real work (Kenny & Allenby, 2012; Stevenson, 2005; Strong et al., 2004). As such it is not seen as a priority (Green Lister & Crisp, 2005; Kenny & Allenby, 2012; White & Winstanley, 2009). This is true for allied health professionals working in mental health, who describe clinical supervision as the first thing to go when there are competing demands (Strong et al., 2004). The result is ad hoc, irregular, informal clinical supervision (Buus, Angel, Traynor, & Gonge, 2011; Cleary & Freeman, 2005; Green Lister & Crisp, 2005; Strong et al., 2004). Along with the ambivalence nurses' perceive that attendance at clinical supervision may be construed as not coping or linked to performance management concerns (Cleary & Freeman, 2005; Green Lister & Crisp, 2005; Kilcullen, 2007; White & Winstanley, 2009). When nurses do engage with clinical supervision a level of personal commitment is often required if implementation is to be successful (White & Winstanley, 2010).

Assumptions about commitment

There are multiple examples where a commitment that is 'above and beyond' is called on from nurses if they are to access clinical supervision (Jones, 2006; White & Winstanley, 2009). The subtext being that this is not real work and cannot be accommodated within work hours (White & Winstanley, 2009). Jones (2006) praises the dedication of two nurses who attended supervision after night work. Other qualitative studies report that attendance at clinical supervision was limited due to nurse unwillingness to attend clinical supervision outside of their shift times (Buus et al., 2011; Chilvers & Ramsey, 2009; Cross, Moore, & Ockerby, 2010; Kenny & Allenby, 2012). Buus et al. (2011) suggest that the nurses' recreational time off was more valued than clinical supervision. To this point it could be argued that attendance at clinical supervision while off duty equates to a boundary violation as defined by the Australian Nursing and Midwifery Council (ANMC) (2010). To demonstrate, if nurses were contacting patients or providing care outside of their work hours there is no doubt that this would be the case. The guidelines clearly specify behaviour that results in singled out treatment including "visiting the person when off duty or swaps roster allocations to be with the person" (Australian Nursing and Midwifery council, 2010, p. 10) is a violation of professional boundaries. The implications of such boundary violations relate to professional ethical codes of conduct. This behaviour described as resistance from nurses could be interpreted differently. The expectation for nurses to attend in their own time could in fact be interpreted as creating a moral dilemma. To address this it is necessary that implementation takes into account the needs of nurses working on rotating 24-hour rosters. This is not impossible. White and Winstanley (2009) found that rosters could be negotiated. This was possible where the person implementing clinical supervision had influence over the roster or with support from managers. Commitment aspects of the debate are related to the

lack of time argument. Active support from management or those administering rosters is necessary to allow dedicated time within work hours to support clinical supervision.

Time equals money

Lack of time and busy workloads are consistently noted across specialties and across disciplines as a barrier to implementing and maintaining clinical supervision (Chilvers & Ramsey, 2009; Cleary & Freeman, 2005; Deery, 2005; Kenny & Allenby, 2012; Strong et al., 2004; White & Winstanley, 2009). The value of having time dedicated to discuss clinical work in a reflective forum is one of the benefits of clinical supervision (Cross et al., 2010). The "too busy" argument loses ground if the amount of time is considered. Edwards et al. (2005) explored the factors that impact on the effectiveness of clinical supervision. To be effective they recommend clinical supervision be held monthly for at least one hour. At a managerial and individual level time needs to be allocated to allow such forums to occur.

The discussion around on whose time clinical supervision should be held draws out further discussion around the need to legitimise this as real nursing work. The cost implications of clinical supervision are yet another excuse used to devalue or dismiss clinical supervision. Sometimes this is described overtly. For example, cost cutting and resource constraints to justify irregular and ad hoc clinical supervision arrangements for child protection workers in the United Kingdom's National Health Service (NHS) (Green Lister & Crisp, 2005). At other times the message is more covert. Managers refusal to pay time in lieu for attendance (White & Winstanley, 2009). Based on fourteen hours of supervision per year, one-to-one, peer supervision the cost of clinical supervision for nurses is 1% of their annual salary (White & Winstanley, 2006). This would be decreased further if supervision was monthly and a group model was implemented. The idea of group format clinical supervision

is one of the main concepts that the authors will now discuss in relation to finding a way to move beyond the current debates and criticisms of clinical supervision.

Finding a way forward

Despite methodological limitations, and resistance from health professionals and organisations there is an argument for positive changes in work satisfaction, decreases stress, burnout nurses well-being and effective clinical supervision (Dawson, Phillips, & Leggat, 2012; Edwards et al., 2006; Hyrkäs et al., 2006; Koivu, Saarinen, & Hyrkas, 2012; Severinsson & Kamaker, 1999; Wallbank & Hatton, 2011). There is also some evidence that clinical supervision can improve patient and staff satisfaction (White & Winstanley, 2010); enhance education, expand scope of practice (Mannix et al., 2006; Moorey et al., 2009) and provide a forum for critical reflective practice (Cleary & Freeman, 2005; Cross et al., 2010; Hyrkas et al., 2002; Kilcullen, 2007).

Diverse local contextual factors suggest a common understanding and uniform implementation is not possible. For clinical supervision to be successfully established in practice, programs will need to be locally negotiated so that they meet the needs of the staff involved. The National Clinical Supervision Support Framework released recently by Health Workforce Australia (HWA) (2011) offers broad principles and clarification of clinical supervision. HWA (2011) recommend that the framework should inform local planning and strategies in a consistent way and not supersede local arrangements. An appreciation of local and contextual factors is consistent with the organisational change and innovation literature that acknowledges that attempts to effect change need to take into consideration the complexity of the local situation (Grol, Bosch, Hulscher, Eccles, & Wensing, 2007).

Alongside the fairly limited body of quantitative evidence there is a large body of qualitative research. It is here that many insights about the benefits and transformational aspects of clinical supervision can be explored. The benefits explored are practice change and innovation, new skills/ confidence that expand health professionals' scope of practice and the generation of shared understandings of care.

Critical reflection to generate shared understanding

Many of the reported positive aspects of clinical supervision relate to the benefits of generating a shared dialogue or the impact of working in a reflective way (Cleary & Freeman, 2005; Cross et al., 2010; Hyrkas et al., 2002; Kilcullen, 2007). Clinical supervision is viewed as a supportive forum (Cleary & Freeman, 2005; Kilcullen, 2007) that increases the value nurses put on their work (Kilcullen, 2007). The need to open professional dialogue is noted within nursing research (Botti et al., 2006). The benefit of open communication amongst peers and more broadly across disciplines has been noted as a positive support for nurses when implementing new and innovative roles such as nurse prescribers (Stenner & Courtenay, 2008). The creation of shared meanings of care and experiences are described repeatedly (Cleary & Freeman, 2005; Cross et al., 2010; Holst, Edberg, & Hallberg, 1999; Stevenson, 2005). This creates the opportunity to develop consensual cohesive practices creating new ways of collaborating (Bondas, 2010; Hyrkas et al., 2002). This shared understanding is described as working off the same page (Cross et al., 2010). Through the creation of shared narratives for patients and health professionals radical talk is generated that is able to challenge dominant ideologies and change work practices (Holst et al., 1999; Jones, 2006; Stevenson, 2005). Clinical supervision provides an experiential way for nurses to understand their work and themselves (Holst et al., 1999; Jones, 2006). This is seen to validate and confirm the nurses in their work. Extending this idea beyond nursing, the

benefits of creating shared understandings through critical reflection on practice may also be applicable across disciplines.

Multidisciplinary team clinical supervision

The challenges of group work, in particular interprofessional group work, should not be overlooked. Working in a group can potentially provoke anxiety. Some of the concerns voiced by study participants relate to confidentiality of the group. For example, group members' suspicions about supervisors' communication with managers (Jones, 2006). Or managers' mistrust of the process and interrogation of supervisors (White & Winstanley, 2009). These anxieties can be exacerbated though open group format in which the group members vary from session to session (Brunero & Lamont, 2012) or when the group is multidisciplinary (Hyrkas et al., 2002). This can be overcome and the group can build and enhance trusting and collaborative relationships (Bondas, 2010; Hyrkas et al., 2002; Jones, 2006; Stevenson, 2005).

Whilst there is a lot of literature that espouses the benefits of interprofessional working (CanNET National Support and Evaluation Service - Siggins Miller, 2008; Hyrkas et al., 2002) there is also literature that suggests that the benefits of interprofessional practice are less clear (Zwarenstein, Goldman, & Reeves, 2009) and that interprofessional practice is hampered by lack of understanding of roles across professions (Mitchell, Parker, Giles, & White, 2010; Mitchell, Parker, & Giles, 2011). Team clinical supervision is described as strengthening professional identity (Berg & Welander Hansson, 2000; Hyrkas et al., 2002). Clinical supervision has the potential to help nurses reconceptualise our position in relation to the need for critical review of our care and decisions, in relation to the authority that we have to seek support as an entitlement and as best practice.

Models of care that bring together the skills and knowledge of a diverse workforce and from diverse settings are being put forward as a means to improve communication, integrate care, and provide role clarity and coordination of care (NSW chronic and complex care) (NSW Department of Health, 2005). Training and education of health professionals is moving to bridge the divide between health disciplines though interprofessional training initiatives (Health Workforce Australia, 2010). Alongside this there is a growing recognition that complex and chronic care requires multidisciplinary approaches (NSW Department of Health, 2005). Links between clinical supervision and other multidisciplinary forums are described by Buus et. al. (2011). They describe parallel forums including interdisciplinary, clinical-case conferences and handovers. However, they found that "the highly-structured agendas for information sharing at these meetings did not leave time for in-depth discussions and reflection on the particular clinical problems confronting the nursing staff." (Buus et al., 2011, p. 99). The strong focus within the literature on efficacy using empiricist research designs to evaluate clinical supervision has failed to recognise the role that clinical supervision can have in strengthening teams through group critical reflection on practice.

Conclusion

There is an ongoing debate around the problems with a diffuse evidence base and the confusion about the role and structure of clinical supervision. To address this clinical supervision needs to be locally negotiated so that it may appreciate the complex contextual factors at a local level. This is guided by an overarching framework. For, example, the Health Workforce Australia National Clinical Supervision Support Framework (Health Workforce Australia, 2011). In order to address the argument that support for clinical supervision is unfounded future research needs to consider issues of rigour. Research must clearly identify

the intended outcomes and designs should consider the complex nature of clinical supervision interventions (Grol et al., 2007; Grol & Grimshaw, 2003).

Resistance and ambivalence from nurses' that perpetuate old-fashioned interpretations of nursing practice need to be challenged. Research needs to explore clinical supervision as a potentially professionally enriching interaction with others that may results in appropriate, safe patient care that is provided in a satisfying work environment. If these results are achievable then research needs to further explore the mechanisms by which these changes are achieved, or not, in which contexts.

Transformational practice in achieved through collaborative, inclusive and participatory approaches to care (Australian Resource Centre for Healthcare Innovations, 2012). Critical engagement with colleagues around patient care has the potential to transform practice. Multidisciplinary group clinical supervision presents itself as an approach to clinical supervision that will break down the silos created by not working across disciplines. It will link the work that is being done around building clinical supervision as a viable and valuable intervention to support health professionals. Group supervision will potentially make best use of scarce funding and time resources. Multidisciplinary session will enable generation of shared understanding of care and the health care experience from a variety of perspectives. This approach will create a space to generate new understandings of difficult or distressing patient encounters. It will also build interprofessional relations and collaborations through the generation of shared meaning of health care. Through this shared understanding health professionals and health care teams will be able to move forward in innovative and exciting new ways.

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