Overcoming the barriers to effective clinical supervision

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Clinical supervision remains one of the most misunderstood practices in modern nursing. It provides a nurturing and supportive service for nurses, helping them to reflect critically on their actions in the provision of patient care. The aim of this article is to explore and examine the current role and status of clinical supervision in the NHS.

Despite having been prominent in health care for well over a decade, clinical supervision remains one of the most misunderstood practices in modern nursing. Described as an exchange between practising professionals to enable the development of professional skills (Butterworth and Faugier, 1992) it provides a supportive service for nurses to help them reflect on their actions or possible inactions in the provision of patient care. The overall effectiveness and quality of care is thought to improve through an increase in professional and personal self-awareness being brought to bear on clinical practice. Driscoll (2000) adopted the view that if properly implemented, clinical supervision is the greatest driver in taking forward excellence in care. Despite this, a continuing lack of understanding combined with underlying mistrust by nurses can still result in obstacles for those attempting to provide supervision to those who need it.

**Background**

The advent of clinical supervision in the NHS has its current roots in certain significant failures of care in the 1990s, including the Bristol heart surgery tragedy and cervical screening mistakes at Kent and Canterbury Hospital (Cottrell and Smith, 2000). Such occurrences served to illustrate the potential for adverse outcomes when health service systems fail.

**Preventing harm to patients**

Perhaps most damaging to the nursing profession was the case of Beverly Allitt, a nurse who deliberately harmed the paediatric patients in her care. Her crimes contributed to the acceleration of a radical analysis of the existing systems intended to safeguard the public. One of the reactions of a health service understandably disturbed by Ms Allitt’s case was the introduction of greater managerial control over nursing practice.

**Maintaining standards and safety**

Clinical supervision, as advocated by Clothier et al (1994), was conceived primarily as a method of protecting standards and public safety through increased vigilance and interprofessional observation of staff. The downfall of such a mechanism was that it relies on cooperation, compliance and voluntary participation to achieve any notable level of success. Also, to assume that individuals such as Ms Allitt would have been truthfully compliant with such a process seems somewhat naive in retrospect.

**The importance of staff development**

At the time of its inception many nurses were not willing to become fully involved with the issue of clinical supervision. However, it has evolved to focus on the supportive process of staff development and improving the quality of patient care. More recently it has been described as a regular, interactive process supported by an experienced, skilled person using a confidential framework to reflect on professional issues and to develop skills (Louden, 1998).

**What is clinical supervision?**

The broad aims of clinical supervision, which include improving nursing practice, patient care and staff responsibility, are listed in Box 1.

Smith (2000) suggested that nurses feel lonely and unsupported in modern times as they rush around trying to comply with standards and charters, which leaves little time for camaraderie and friendship to develop. Such feelings of hopelessness are likely to adversely impact on the nurse-patient relationship.

No matter how rose-tinted and nostalgic the retrospective experiences of caring and job satisfaction may

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**Learning objectives**

Each week *Nursing Times* publishes a guided learning article with reflection points to help you with your CPD. After reading the article you should be able to:

- Know the objectives of clinical supervision;
- Understand the process of clinical supervision;
- Identify the barriers to effective clinical supervision;
- Identify ways to overcome the barriers to clinical supervision.
be, the quality of the care that nurses deliver could suffer if they start to feel alone and isolated. This can impact on their capacity to care for others. Clinical supervision should aspire to help address such situations.

Examining barriers

Defining clinical supervision

Clinical supervision originally had a less than stellar impact in some areas of nursing, the residual effect of which is still in evidence today. Much of the problem involves a tremendous confusion over definition. Definitions of the subject are many and varied and such diversity serves only to blur understanding.

Although there is a growing body of research that shows supervision to be effective in reducing the work-related stress of nurses, much of it continues to be methodologically flawed and blighted by problems of definition (Cottrell, 1999).

Indeed, the very term ‘supervision’ may still conjure up images of some form of organisational surveillance, which is instantly misleading and perhaps counter-productive in encouraging nurses to pursue the subject. All too often the misconceived nursing perspective is one of supervision being a process of criticism designed to attribute blame.

Faugier (1992) pointed out that nurses generally experience unease and discomfort with a phenomenon that they feel signifies ‘self-indulgence’ and are quick to avoid it as a result.

Conversely, Yegdich (1999) expresses concern that nurses, having fostered the need to constantly self-examine and reflect, run the risk of lapsing into ‘self-absorption and narcissistic preoccupation’.

The fear is that the widespread embracement of supervision consequently breeds a culture of introspective contemplators who are increasingly detached from their patients and their work.

This view is perhaps a little too cynical if it is remembered that nursing is a profession historically renowned for rejecting the fanciful in favour of caring, compassionate and well-balanced common-sense approaches.

Who carries out clinical supervision?

Many line managers provide clinical supervision to their staff and this in itself may be problematic:

- Staff may not have chosen that person as a supervisor;
- Staff may not wish to disclose personal material to such a person;
- Staff may feel that a negative evaluation by a line manager could have a direct influence on their future career success.

Fear of a loss of autonomy, as identified by Bond and Holland (1998), is another common factor.

Managers themselves may feel that supervision carried out by other individuals for their staff might erode and diminish their power, control and authority.

Also, Swain (1995) observed that there is a frequent tendency to incorrectly view clinical supervision as being indistinguishable from individual performance review. This is in direct conflict with the view of the RCN (1999), which clearly states that clinical supervision is a completely separate entity from a formal performance review and warns against confusing the two.

Imposing supervision

Other barriers stem from supervision being imposed on the individual by the organisation rather than being a component of personal and professional choice.

Cole (2002) concludes that clinical supervision is still regarded with suspicion by many nurses and that there are certain initiatives that are essential to rectifying this situation, including voluntary supervision, choice of supervisors, confidentiality and reassurance that there will be no repercussions.

Confidentiality

Regarding confidentiality, Mackintosh and Ashman (1999) acknowledge that if clinical supervision is to facilitate real staff development it requires considerable trust from both parties. However, it would be reasonable to expect a breach of confidentiality being occasioned under certain circumstances, for example in the event of any admission of action or inaction putting a patient’s welfare at serious risk.

Confidentiality needs to be addressed in a sensitive manner by the organisation in its operational policies, otherwise, as pointed out by Bond and Holland (1998), supervisors and the staff who are under their supervision will be inclined not to keep records, especially as such records are technically considered the property of the individual by the organisation rather than being a completely separate entity from a formal performance review.

Organisational barriers

Ultimately the challenge of implementing clinical supervision appears to lie in breaking down the barriers of the organisation (McSherry et al, 2002).

This view is supported by Clifton (2002), who stressed the need for organisational support in order to raise awareness and correctly ‘sell’ the value of clinical supervision to both staff and managers.
Overcoming barriers

Barriers to the implementation of change tend to fall into two categories, personal and organisational (Rees, 1997). This is supported by Bennett et al. (2001), who agree that barriers to the implementation of clinical supervision range from individual factors to wider organisational issues. In order to effectively overcome these barriers, they first need to be understood.

Personal barriers

Personal barriers relate to the way in which individuals perceive themselves in relation to the process of clinical supervision. They are governed largely by primal emotive factors, such as fear of change, lack of confidence, knowledge, skills or understanding, failure to recognise the need for supervision and reluctance to let go of old routines and work habits.

Communication barriers

To improve understanding and prevent confusion, the principles of clinical supervision need to be communicated in clear and accessible language that stresses the benefits to patients and staff as well as to the organisation. The architects of supervision need to promote the concept simply and explain its relevance. It is vital to provide a clear definition of what clinical supervision is, what it does and how it works.

Two definitions provide an accurate overview:

- The Department Of Health’s definition explains how supervision provides a support system for practitioners to ensure the provision of high-quality treatments and services through the evaluation of practice and by encouraging practitioners to learn from their experiences (DoH, 1999).
- The RCN (1999) states that clinical supervision involves the meeting of one or more other nurses regularly to discuss aspects of work in order to think critically about practice, check procedure and deal with emotional issues arising from work.

Teaching sessions involving complex presentations and obscure training videos are likely to be alienating turnoffs and will not help to get the message across. It is more preferable to use a strategy that is underpinned by direct and straightforward communication (Walsh, 1997), something that should be a beneficial component of any practical user-friendly method of education.

It is worth clearly emphasising what clinical supervision is and what it is not.

Clinical supervision is not:

- A management tool;
- A method of surveillance;
- A formal performance review;
- A form of preceptorship;
- Counselling;
- Hierarchical;
- Criticism of the individual as a nurse or a person;
- A form of therapy.

Clinical supervision is or aims to:

- Support nurses;
- Provide relief from the emotional and personal stress involved in nursing;
- Help nurses work in an effective way;
- Help nurses gain information and insights, and develop and make the best of their work;
- Encourage professional growth;
- Be a part of lifelong learning;
- Be a component of clinical governance;
- Be an aid to improving the quality of nursing care;
- Be for nurses and about nurses.

Owning the process

Clegg (2000) believes it is important to give staff a feeling of ‘ownership and participation’ in relation to processes that affect them, as this helps to nurture positive responses to those processes. This could involve seeking opinions and input from nurses and emphasising that supervision is directly for and about nurses and nursing.

In addition, the notion of supervision being compulsorily enforced on nurses needs to be addressed. Under such circumstances, it is unlikely to elicit tolerance, committed support or full cooperation. The RCN (1999) agrees that supervision is not normally compulsory and that nurses should choose whether to have it or not (although there are some cases where it is a contractual condition of employment). The individual choosing to have it must make a commitment to attend meetings on time and be prepared to discuss issues. The supervisor makes the same commitment. The individual chooses what to discuss and what not to discuss, as this affects the agenda.

It should also be understood that people being supervised are in a position to choose who they want to supervise them. Likewise, the supervisors should have the option of whether they supervise specific individuals or not. Any incompatibility between the supervisor and the person being supervised should be minimal.

Organisational barriers relating to clinical supervision are prone to result from political conflicts, lack of understanding, constraints on nurses’ time and limited...
resources. Gilmour (2001) acknowledges that few health organisations include clinical supervision in their corporate agenda or business plans and argues that time needs to be built into practitioners’ workload schedules for preparing for and attending meetings. Time for supervision is a crucial factor and an area where the financial cost of the process becomes most influential.

An appropriate environment for supervision to take place is another requirement, but most critical is the provision of trained supervisors to choose from, a list of which should be available in every clinical area. All organisations need to have a policy for the training of supervisors and resources. Gilmour (2001) acknowledges that few health organisations include clinical supervision in their corporate agenda or business plans and argues that time needs to be built into practitioners’ workload schedules for preparing for and attending meetings. Time for supervision is a crucial factor and an area where the financial cost of the process becomes most influential.

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Although health organisations may agree with supervision in theory and realise the value of it, they may still need to do more in terms of facilitating supervision through the provision of time and resources for those already involved and those wanting to get on board. Enthusiastic, committed and dynamic approaches from managers in these organisations are important to ensure success in negotiating organisational barriers.

Clinical supervision – a brief descriptive framework
A description of the process of clinical supervision will help enhance and promote understanding.

The concept
Twinn and Johnson (1992) proposed that clinical supervision enables practitioners to be creative. In many respects the process can resemble a creative art or skill in the way that the emotional expression of clinical practice can be analysed.

In order for nurses to clearly perceive aspects of patient care, the emotional effects of caring that impinge on nurses need to be brought to a state of rational stability. The establishment of a balanced psychological perspective helps to enable constructive thought that is conducive to improving quality of care.

The art of the supervisor lies in inspiring and facilitating critical reflective practice in the person being supervised. Attention is given to the emotional needs of the person under supervision, how she or he has been affected by experiences and how to deal with those experiences constructively. This has been termed the restorative function (Proctor, 1986).

For the person under supervision the benefit lies in considering the creative application of the outcomes of reflective practice. This is achieved through a combination of guided discourse and shared exploration. Therefore, understanding past situations helps to find solutions for future practice.

The practicalities of care
Supervision focuses on developing skills, understanding and ability by reflecting on and exploring the work of the person being supervised. The more abstract emotional concepts require linking in with the real practicalities of administering quality nursing care.

Combining and applying
Ultimately the conceptual and practical aspects of clinical supervision need to be combined. This takes place through the relationship between the supervisor and the person who is being supervised. Interaction and discourse strive to achieve the goal of increased self-insight and awareness.

The means by which the person being supervised can appropriately modify and enhance attitudes and approaches to patient care becomes apparent through the drawing together of the relevant threads. The desired outcome involves recognising the best thing to do, the best approach to achieve it, and then carrying it out in future situations (Fig 1).

Conclusion
Swan and MacVicar (1992) recognise that people naturally want things to remain stable and that many forces encourage the retention of the status quo. Nursing is a profession where this has been cited as a frequent barrier to change and progress in the past and continues to hold true in some areas today. Continued innovation is vital for the nursing profession to survive and develop.

Mahood et al (1998) claim the value of clinical supervision is in allowing nurses the freedom to develop their skills in response to patient need. It should offer ways of enabling practitioners to expand their knowledge to meet these demands. Among the mechanisms supporting personal and professional development, clinical supervision is considered to be a significant benefit to both nurses and patients.

REFERENCES


