From a policy perspective, clinical supervision within the nursing profession in the UK was first formally highlighted in 1993 and has continued to gather policy momentum (Department of Health, 1993; UKCC, 1996; UKCC 2001). While the early literature on clinical supervision provides evidence of its exploration and development within the profession, it does not describe its nature or the change experience of introducing it.

Method
This study was designed to investigate the nature of clinical supervision by exploring how and why it was introduced. At the study site, clinical supervision was new in terms of concept and practice. The action research study took place from 1997 to 2000 within one area of an acute general hospital in Scotland where 385 nurses were based.

Within the four-cycle action research approach qualitative data was collected using a range of methods and analyses. The findings indicated the complexity of change required to support the introduction of clinical supervision and the complexity of clinical supervision itself as a new and distinctive form of supervision.

Initially clinical supervision was introduced to 14 deputy ward charge nurses. The study was extended to include approximately 100 other nurses of various grades from within the study site across three study cycles (year one). Throughout these study cycles, several problems and issues were identified and remedial action initiated as a basis for a fourth and final cycle (year two) in order to extend the provision of clinical supervision to all 385 nurses within the area. However, during the fourth and final cycle, the practice of clinical supervision decreased rather than increased as expected. One of several insights gained into why the planned change did not occur centred upon the importance of relationship development.

Within the study, clinical supervision was defined as given by the Department of Health (2003) and was based on the model of supervision espoused by Proctor (1986). One-to-one peer supervision was generally thought to best meet the needs and abilities of the 14 initial participants.

Cycle 1: The first three months
After the first three months of clinical supervision all participants made reference to the clinical supervision relationship in which they had been involved. Half of the participants had chosen their partner, and the rest had been allocated a clinical supervision partnership. The role of the supervisor or supervisee was allocated within each partnership.

For some participants, starting off in their respective clinical supervision relationships had been made easier because they already knew their partner.

'I found it quite easy. The fact that I knew her [my partner], I trust her and I felt as if I could say anything to her. Sitting listening to others in the group, they feel more comfortable discussing professional matters with someone they don’t know, so I think it’s down to the personality and what you feel comfortable with yourself.’ (Dorothy)

The importance of choice in clinical supervision partnerships, although not referred to directly, was considered important by several participants as it facilitated their establishment and the subsequent development of sound relationships built on trust and confidentiality.

'There are people who I can sit and “blether” to in the tea room and things, and you could have partnered me up with them. I would never trust them, although I get on fine with them.’ (Katy)
Findings also showed that ‘not knowing’ one another was a key factor in the early clinical supervision relationship. Not knowing one another appeared to provide more initial difficulties in terms of comfort, thereby hindering the establishment of a sound relationship for clinical supervision.

However, knowing each other was not sufficient in itself to ease the establishment of a clinical supervision relationship. It was a combination of knowing, comfort and trust that made the difference.

‘But I would say, in the second, third and fourth meeting we’ve been a lot better, we’ve managed to talk about things that were very confidential, and things that I was surprised at her discussing with me, to be honest with you. So I was quite pleased because at least then I knew that she was trusting.’ (Holly)

In terms of their respective clinical supervision relationships, there was therefore evidence to suggest that development had occurred over the first three months. All participants indicated a greater sense of comfort within their relationship compared to at the outset. This sense of comfort appeared to relate to the degree of trust and confidence experienced during clinical supervision.

In a case study of clinical supervision, Jones (1997) highlighted the importance of trust and confidence in supervisory relationships. He drew on findings from supervision in psychotherapy and counselling, such as the dearth in nursing, to focus on the importance of trust in supervision. Trust was identified as an essential component of empathy, the essence of a safe environment (confidence) for effective supervision to ensue.

If there was no trust, there was no relationship. If there was no relationship, there was no effective supervision. In this study, while knowing one’s partner appeared to aid initial comfort within the relationship, it was the development of trust and confidence that was the key to that relationship becoming more purposeful, affirming Jones’ finding. Effective relationship development was evidently important to effective clinical supervision even at this early stage.

**Cycle 2: Three to six months**

In the second three months, the initial partnerships were maintained but the roles were reversed. Greater insight was provided into aspects of the clinical supervision relationship. Participants, based on their respective experiences of clinical supervision to date, shared a number of points that were considered to be of importance in future relationships for themselves and for others. About one-third of participants thought that having a different clinical background from their clinical supervision partner was not a problem.

‘I wouldn’t personally like somebody from my own area as my supervisor. I don’t think it’s necessary at all. Well, one thing that concerns me, in your own area, to be quite frank about things, confidence worries me terribly. And I think if it’s someone removed from your own area, then it’s less likely to be a breach of that confidentiality. Because, as nurses, we have common experiences, regardless of where we work, without a doubt.’ (Mags) Such expressions continued to be underpinned by the importance of choice, that is, being able to choose one’s own clinical supervisor.

‘I think it [choice] is important. I think it’s necessary to be able to choose your supervisor.’ (Nora)

With regard to the support provided in supervision, Proctor (1986) highlighted the fact that freedom to choose with whom one entered and developed a clinical supervision relationship was equally important to gaining comfort within a relationship.

‘I knew her [my partner]. We didn’t pick one another, but I’d worked with her for a long time, so I think the ice was broken.’ (Ally)

At this juncture, participants were anticipating the potential of an additional clinical supervision relationship in order to commence the cascade of involvement of others within the organisation. From their experiences of peer one-to-one supervision to date, the freedom to choose and feel comfortable in one’s clinical supervision relationships was of crucial importance to the subsequent quality of that relationship and ultimately for clinical supervision itself.

These features, reflective of arguments made but not empirically based within the literature, had begun to emerge during cycle 1 and had continued to develop in cycle 2, being perceived by participants as profoundly important in underpinning future effective clinical supervision through effective relationship development.

**Cycle 3: Six to 12 months**

At 12 months into the study, most participants had made some reference to their clinical supervision relationships (each had a minimum of three and a maximum of four) supporting earlier findings. For example, one participant echoed the importance of knowing one’s partner in advance of entering a clinical supervision relationship.

‘We seem to interact well. I find that I can talk to her freely about any subject.

‘I have known and worked with her for many years and I think that this probably facilitates our partnership. We are both the same grade and share similar clinical interests and specialist elements of the job.’ (Izzy)

However, for one participant, again reiterating earlier findings, the positive experience was dependent on having a clinical supervision relationship with

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someone outside the immediate environment.

‘An issue I feel strongly about is not having a relationship in the same ward. It is much more refreshing to have outside influence and confidentiality respected.’ (Maggis)

The recurrent theme to emerge was that of the positive experiences of a clinical supervision relationship developing over time. With that development, at least one-third of participants experienced greater feelings of trust with their partner, contributing to a growth in the range and depth of issues raised during clinical supervision sessions.

‘As the relationship developed it became easier to discuss a broader range of issues. I think this is because we had built up more trust and confidence in the partnership.’ (Frances)

For most participants, therefore, there was evidence that their experiences of clinical supervision had developed positively over time, contributing purposefully to their experience of clinical supervision.

In terms of relationships within clinical supervision, it was interesting to note that although some of the initial issues had been resolved, some participants were still commenting on initial difficulties. Entering a clinical supervision relationship was evidently not easy for everyone, particularly at the beginning. Any new relationship appeared to require choice through which an associated sense of comfort and trust could develop. Such comfort and trust appeared to lead to more effective clinical supervision. Such comfort and trust appeared to lead to more effective clinical supervision, which was illustrated by the greater range and depth of agenda raised countered only by the supervisee’s perception of their supervisor, as found by Stapleton et al (1998).

**Cycle 4: 12 to 24 months**

At the end of the two-year study, there was evidence of much more critical appraisal of relationships, and its effect on clinical supervision and its sustainability or not. While choice and initial comfort continued to be recognised as important, most participants acknowledged that for clinical supervision to be effective more was required than had been available from their peer relationships. For these participants, the quality of clinical supervision was dependent on the perception of the individual under supervision of the level of the supervisor’s ‘seniority’.

‘Although it’s supposed to be non-hierarchical, if it’s about professional development then it is normally someone above you with more experience that would offer the best supervision, provided its based on a trusting relationship.’ (Holly)

This was an important point, reiterated by most participants, and somewhat contradictory to the espoused professional view on non-hierarchical clinical supervision (UKCC, 1996; UKCC, 2001). If, as occurred in this study, the relationship did not develop beyond comfort, trust and confidence, then clinical supervision ceased to be practised.

Based on reflection of their experiences of clinical supervision, participants appeared to recognise that relationships required more than the comfort, trust and confidence recognised in cycles 1, 2 and 3. A clinical supervision relationship also had to offer an element of challenge for maximum effectiveness, a challenge that can only be provided by somebody more ‘senior’, that is with greater capabilities than oneself. This may be elusive in peer supervision.

‘Given that you’re in a position of selecting your supervisor, truthfulness is needed. If that dissipates so does the quality of supervision. I am seeking to be supervised by someone who I perceive as being more experienced than myself. So you seek constant criticism and challenge from clinical supervision and respond to it.’ (Babs)

**Discussion**

Figure 1 illustrates relationship development within the study. Initially, choice is fundamental to comfort. Choice and comfort are essential in the development of trust and confidence. Trust and confidence are necessary to cope with challenge.

Challenge, based on the data from the final interviews of the study, appeared to be an essential component for effective clinical supervision if it was to be purposeful.

**Choice and comfort**

The importance of choice of supervisor appears to be a prerequisite of comfort for these participants. Comfort was a factor that participants felt encouraged them to raise and explore their respective agendas.

A hesitant start in raising agendas in clinical supervision meetings was aided by greater feelings of comfort with their supervisor. The contribution of comfort to effective learning and development

### FIG 1. FEATURES OF RELATIONSHIP DEVELOPMENT IN CLINICAL SUPERVISION

- **Choice**
- **Comfort**
- **Trust and confidence**
- **Challenge**
(cornerstones of clinical supervision) was recognised throughout both educational and nursing research in the 1980s (Fretwell, 1980; Ogier, 1981; Alexander, 1982; Lewin and Leach, 1982; Entwistle and Ramsden, 1983; Rogers, 1983; Knowles, 1984; Boud et al, 1985; Reid, 1985; King, 1986; Jacka and Lewin, 1987; Melia, 1987).

It would appear that clinical supervision also requires an effective environment and that the conditions of that environment are similar to those required for learning. If the appropriate conditions do not prevail then clinical supervision, like learning, cannot flourish.

**Trust and confidence**

Trust and confidence in clinical supervision relationships also appears to be important in protecting the personal boundaries of individuals. This seems to be of particular significance when clinical supervision is being conducted in-house, even if one’s supervisor is chosen and does not necessarily include an immediate line manager.

**Challenge**

The essential part played by challenge in a supervision relationship only emerged in the latter part of the study, in cycle 3 and more clearly in cycle 4. Challenge was critical in determining the extent to which clinical supervision was perceived as worthwhile and therefore sustained or not.

Fundamentally, if challenge was low this affected the pursuit of clinical supervision as evidenced by most participants, who declined in their practice of it in cycle 4. However, challenge was a later aspect of relationship development and required the preceding stages of choice, comfort, trust and confidence to be present. The need for challenge, however, further emphasises the ongoing need for choice. For if challenge does not present itself after comfort, trust and confidence, then as was evident in this study, when challenge did not present itself clinical supervision ceases to be pursued.

Comfort, trust and confidence were essential but not sufficient for an effective clinical supervision relationship. Figure 2 should therefore replace the previous figure to better describe the most effective clinical supervision relationship.

In Figure 2 each component of the relationship development journey must be underpinned by the availability and the exercise of choice by the supervisee. However, in the absence of confirming evidence from any other clinical supervision study, such a model is worthy of further study, while also assessing its feasibility within a large workforce devoid of additional resources for introducing clinical supervision.

Such a finding also confirms the necessity for longitudinal study of clinical supervision for, as in this study, there may be development beyond what is found in the early stages. However, there is currently no substantial, longitudinal study evaluating clinical supervision beyond the initially supported endeavour, a view supported by Arvidsson et al (2000).

Arvidsson et al (2000), while reporting positive outcomes in respect of growth of professional competence in a small group of psychiatric nurses who had experienced group clinical supervision, identified that a long-term follow-up research project was required.

Such a study ‘ought to give valuable information on whether or not group supervision in nursing care has lasting effects on nurses’ professional competence.’ A similar argument arises from the findings of this study.

**Conclusion**

Based on the persistent and unequivocal reporting of value, clinical supervision should be introduced within general nursing (Butterworth et al, 1997; Gilmore, 1999).

However clinical supervision must be ‘good enough’ as highlighted by Scanlon and Weir (1997). If it fails to be good enough, clinical supervision will cease to be practised and nurses will be denied a practice that appears to offer a valuable alternative to existing supervisory systems.

One factor to be taken into account is the quality of the relationship. If freedom of choice is not available or is not exercised in achieving all components of an effective relationship then not only is the quality of the relationship within clinical supervision open to question but so is the quality of clinical supervision itself.

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