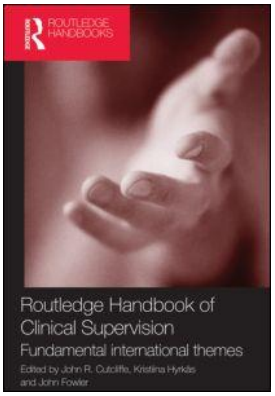

Routledge Handbook of Clinical Supervision Fundamental International Themes

John R. Cutcliffe, Kristiina Hyrkäs, John Fowler

The realities of clinical supervision in an Australian acute inpatient setting

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20 The realities of clinical supervision in an Australian acute inpatient setting

Michelle Cleary and Jan Horsfall

This chapter draws on the findings of an ethnographic study of Australian acute inpatient mental health settings, which sought to better understand the cultural realities of clinical supervision (CS) for this culture/population (see Cleary and Freeman 2005). Having outlined the research design and key findings, this chapter then discusses the findings in light of current literature and highlights some future considerations/issues that will need resolving, if CS is to become a widespread reality in Australian acute inpatient mental health settings. It is noteworthy that this chapter shows how many of the mental health nurses in acute inpatient mental health units, when asked, formally agree that clinical supervision is important, but informally regard it as having a limited experiential value. This may in part be attributable to many nurses believing that they are already involved in CS, though these experiences do not correspond with established definitions of formal CS.

In the view of the editors this chapter, as with some others in this book, offers further evidence of the miscomprehension and misunderstanding that many still have regarding the nature and purpose of CS. This consequently further underscores the need for a shared nomenclature; given that (all) sciences need understandable, stable and internationally-accepted systems for naming and categorising phenomena within the boundaries of the disciplinary area. It can be argued that CS needs this list of agreed names, definitions, principles, rules and recommendations that govern its formation, use and application. Until we have this, there is little surprise that the outcomes of engaging in a variety of practices that share only some (if any) of CS's rudiments, principals and practices bear little or no resemblance to those outcomes which are more commonly encountered when one engages in real, high quality CS. As the authors point out, the belief that existing structures inherent to nursing practice already convey the benefits of CS may contribute to the culture of passive resistance to it.

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Introduction

There is extensive published literature on the topic of clinical supervision (CS), but despite decades of discussion about its potential benefits, there is confusion about

nurses' understanding of CS and the pragmatics of implementing appropriate models (Cleary and Freeman 2005, 2006). For example, in a recent systemic literature review and methodological critique of empirical studies of clinical supervision, Buus and Gonge (2009) concluded that there was limited empirical evidence to support the claim that clinical supervision is a good thing, and does what the promoters claim it does. There is also limited evidence that CS enhances supervisee knowledge and skills, or improves nurse–patient effectiveness (Bradshaw *et al.* 2007; Hines-Martin and Robinson 2006; Scanlon and Weir 1997; Sloan and Watson 2001). Hence, as well as ambiguity, there are disagreements over issues of CS theory, practice and research (Buus and Gonge 2009; Rizzo 2003). This confusion could be seen as mirroring that of mental health (MH) nurses working in acute inpatient units, and there is unlikely to be further clarity until nurses' perceptions are more fully understood. In this chapter, we commence by presenting an overview of findings from an ethnographic study that sought to better understand the cultural realities of clinical supervision in acute inpatient mental health settings (Cleary and Freeman 2005). We then discuss these findings in light of current literature and provide some future considerations if CS is to become a widespread reality in acute inpatient mental health settings.

Cultural realities of clinical supervision: an overview of the findings

Research respondents identified CS as a 'supportive' forum for nurses to 'ventilate concerns/problems' in a non-judgemental, collegial, confidential way, as well as discuss practice issues with peers. The 'exchange of ideas' and access to peer 'support' provided an opportunity to explore 'clinical strategies' and 'reflect on and develop clinical skills' and some nurses indicated that they would 'like to continue with clinical supervision'. CS has been promoted as a way of increasing 'self-awareness' and 'confidence', thus leading to greater job satisfaction. One participant reiterates the value of reflection on practice for the present and the future:

> I think reflection is very important … we're going to experience lots of things and being able to honestly reflect on how we handled the situation or how we saw somebody else handle the situation is the best way.

Some nurses, particularly those newer to the setting, discussed over-identification with patients as potentially problematic. Reflective practices provide an opportunity to explore feelings, and commonly nurses do this with colleagues through peer review, preceptorship programmes and discussion. If boundary transgressions are made by novices, more experienced nurses or peers would take the individual aside and have an impromptu talk for the benefit of nurse and patient. Sometimes nurses are convinced it is 'your colleagues who know you best … who'll come up and say "Just sort of step back for a while".' Thus, informal approaches to preventing boundary transgressions were viewed by nurses to be more relevant to current clinical circumstances despite the promotion of CS as a means of ensuring that staff practise in an 'ethical manner'. Overall, reflection on practice was identified by many participants as providing a level of transparency in the negotiation, delineation, and management of boundary issues, resulting in greater confidence and self-awareness.

Thus, nurses are certainly aware of many of the advantages conveyed by CS but many prefer ad hoc coping methods such as informal sharing and eliciting the support of trusted colleagues, rather than more formal approaches. The need to 'take time out and ventilate' with caring colleagues was believed important with discussion occurring in the privacy of staff offices away from patient care areas. Although this option was not available when patients were acutely disturbed or distressed and/or required a high level of observation, informal support with one's peers was seen to be more flexibly responsive to the clinical realties of everyday work as, generally, colleagues were available and accessible.

The findings clearly demonstrate a strong team culture and nurses described colleagues as being 'really supportive'. Teamwork and collegial relationships were considered part of the 'nature of the work' and provided opportunities for peer review and supervision. There were a number of formal strategies in place to facilitate good communication within the team including: informal consultation; nurse-multidisciplinary team handover; case review; multidisciplinary team meetings; nursing handover; and staff meetings. In addition, collegial relationships encouraged the sharing of nursing workloads, helping nurses to cope and manage competing demands. The notion of 'teamwork' (amongst nurses and other health professionals) was also believed necessary for 'effective' care, and therefore a worthwhile goal in itself.

Respondents considered it to be particularly important for experienced staff on the team to spend time with less experienced nurses or nurses 'new to the ward' to provide education, support and opportunities to evaluate practice and interactions with consumers. This was commonly referred to as preceptorship or CS. Preceptorship can be helpful for more experienced nurses too by giving them access to different perspectives and challenging accepted yet possibly outmoded nursing interventions or approaches.

> …when you're in the system for a long time, you tend to get into a routine but when you have someone fresh … say, '…I don't really feel comfortable with the way you do that' … It makes you think, perhaps I've been doing it for so long I think it's perfect, but it's not.

Discussing the complexities of practice with colleagues and finding solutions to nursing problems was considered essential, and many nurses told how their confidence in their practice had grown and developed through 'reflective practice', the passing of time, 'day-to-day encounters' and 'experience'.

Ward peer supervision and other informal supports identified by nurses may account in part for the perception that CS was already occurring (or was about to) when in fact it was not. This belief may be further reinforced by an awareness that all clinical staff 'are expected or required' by management to receive CS. However, the lack of emphasis placed on CS by nurses may also be attributed to some of their more generic beliefs about the profession of nursing itself. Nurses believed patients were well looked after, the unit was 'effective', worked 'very well' and was 'a good place to work'. There was a sense that the only people who can really appreciate the subtleties and complexity in the unit are other mental health nurses: 'you can sort of stand back and debrief with other people who understand … the only people that can really understand are the people who work alongside you'.

Paradoxically, what respondents liked about their work were the things they found frustrating. This included the challenging, hectic and unpredictable nature of acute care, and the constant pressure and demands. They described each day as 'different' with the work characterised by 'uncertainty' and 'crisis'; to the extent that almost everything was 'urgent'. One-to-one CS was considered impossible due to unit constraints but group supervision had previously been established. The CS group was open which meant those nurses on duty on the day of the group supervision attended. The pragmatics of rotating rosters (e.g. leave, night duty, days off, staffing and skill mix) meant it was difficult to organise dates that suited the same group of staff. This reportedly led to difficulties with 'rehashing' of the same topics with different nurses and everybody wanting to 'talk at once'. Whilst it was deemed important to have a focus for the group, some nurses believed that issues discussed were 'not resolved' and that for clinical supervision to be useful, the 'concerns' of staff must be acted upon. There was a generally held belief that CS should not be mandatory, particularly group supervision.

Most nurses had a clear understanding of supervisee and supervisor roles and responsibilities, but there were differences in opinion regarding how clinical supervision could be improved. Some would prefer one-to-one CS, others believed that the time of day the supervision was scheduled (at the end of the shift when nurses are tired) was an issue. If held outside of work hours, there was a general belief that 'time in lieu' should be granted. Participants did not actively pursue individual CS opportunities and questioned its feasibility, identifying 'time and staffing levels' as constraints. Thus, despite a unit policy of offering CS, 'in reality it just isn't feasible and doesn't work'.

Discussion

CS was nominally endorsed but in reality, other informal means of acquiring professional support and guidance inherent in mental health nursing provided many of the benefits usually ascribed to formal supervision. This may explain the absence of a commitment to clinical supervision as the other informal and formal support strategies identified by participants were possibly more naturalistic and accessible. They also provided a daily opportunity to reflect on reactions to the patient, the nature of professional relationships, and nursing strategies, without creating extra stress due to time taken away from unit and work building up. As nursing has become more complex and demanding, reflective strategies are essential to acknowledge experiences, process responses, question practices, refine problem solving, and develop acceptable professional parameters.

Supportive nursing relationships can provide a sense of belonging and an opportunity to learn in a respectful manner from senior staff, particularly for nurses newer to mental health. Taking time out to discuss problematic situations, accessing senior nurses, role models and ad hoc supervision is helpful for professional reflection, stimulating a sense of security, providing guidance, and offering a new perspective. This approach may also have been preferred as it is difficult for nurses to overtly identify themselves as stressed or not coping and formal attendance at CS could be perceived as an admittance of this. Complementary literature also recognises that support is crucial for busy mental health nurses working in stressful environments to contain anxieties, and prevent fatigue and stress (Flood *et al.* 2006; Hummelvoll and Severinsson 2001).

In the current study a strong team culture was important and existing team strategies (e.g. nurse-multidisciplinary team handover and team meetings, nursing handover etc.) convey some of the benefits of CS and could possibly be considered a form of peer supervision. The cultivation of an environment where nurses feel comfortable talking about daily concerns contributes to safe and therapeutic practice, whereas formal CS is reliant upon honesty and self-disclosure by the supervisee, however skilled the supervision.

Non-formal CS activities fostered mutual respect and trust as well as good and easy communication, aspects essential for effective clinical teaching and learning. Some senior nurses questioned their own practice in response to 'left-field' comments from more junior staff, thus the relationship was rendered more reciprocal and fluid, adapting to the exigencies of 'here-and-now situations'. Daily access to peer supports may have contributed to the belief held by many nurses that they were already undertaking CS, despite these informal approaches not fitting with established practices of formal clinical supervision. However, this is not an uncommon scenario. In another study, supervisees confused CS with de facto clinical supervision, time out and common sense; in fact many understood they had been partaking in clinical supervision for years (White *et al.* 1998). Further, the positives of this informal approach such as flexibility, a focus on support, and familiarity with colleagues, may limit impartiality and make discussions vulnerable to the personal agendas of the staff involved.

The pragmatics of rotating rosters in this setting necessitated an open clinical supervision group, and changing participants undermined group cohesion and trust. The disadvantages of the open CS group format included a reluctance to self-disclose, an absence of focus and repetition of content. The diverse, unpredictable clinical demands inherent in everyday work inevitably limited access to group CS and, potentially, nurses' preparedness to invest their time and energy in it. Supervisee anxiety, issues regarding confidentiality, the professional background and experience of supervisors, and the demands that management might place upon accessing information discussed during supervision are recognised elsewhere (Jones 2003; Nicklin 1995). These issues may be tempered by using experienced external supervisors which has the advantage of being perceived by staff as impartial with clear delineation between the needs of management and the role of the supervision.

To summarise, whilst some participants were positive about CS in theory, in reality, cultural beliefs about its role, structural barriers, and the perceived effectiveness of informal supports meant many nurses did not perceive a need for formal CS. Thus, implementing CS requires the consideration of multiple factors including the definition of CS, existing nursing culture, resourcing issues, expansion of the evidence base, and ensuring CS models are tailored to the real vagaries, urgency and diverse ongoing pressures in acute mental health inpatient units.

Further considerations

In nursing, models of CS are often trumpeted without consideration of the facility characteristics or the everyday reality of the work environment. There is limited empirical evidence to unequivocally support CS's contributions to practice improvement, let alone better patient care, but the literature conveys the impression that

our knowledge on this topic is more robust and trustworthy than it actually is (Buus and Gonge 2009). Despite extensive unequivocal discussion on CS, the reality is that there are very few published examples of its successful implementation in acute inpatient mental health facilities. Although it is claimed that there are efforts currently underway to build clinical supervision into normal mental health nursing practices (Brunero and Stein-Parbury 2008; Edwards *et al.* 2006), others note this as an aspiration rather than a reality (Grant and Townend 2007) and there are clearly problems with its implementation (Rice *et al.* 2007). It is also unlikely that large-scale investment of funds will be allocated until there is unequivocal evidence of a causal relationship between clinical supervision, improved patient care and better nursing care (White and Roche 2006). White and Roche's (2006) recent study showed that clinical supervision is not embedded in the culture or routines of most Australian mental health facilities (see also Cleary and Freeman 2006).

Limited attention has been given to the cultural and organisational context that shapes the CS practice (Grant and Townend 2007). Research has revealed concerns from nurses about the practical benefit of clinical supervision, the time taken away from patients when attending, the additional burden placed on colleagues while they are undertaking supervision and the potential for the supervisor to judge or criticise (Arvidsson *et al.* 2000; Fowler 1996a, 1996b). In order to prevent clinical supervision being viewed as an additional burden to acute inpatient mental health practice, it is important to clarify its aims, benefits, and most effective models. CS should also be clearly defined with specific roles and responsibilities. In addition, preceptoring and mentorship programmes are often already established in inpatient settings and encompass many elements of clinical supervision.

Further challenging the development of a culture of clinical supervision in inpatient settings is that nurses tend to work from a common diary which determines their daily activities making it difficult to prioritise time for CS. In allied and medical professions CS has evolved mainly because of the autonomous nature of the work but mental health nursing often has a strong interactive and mutually supportive culture (Cleary and Freeman 2005).

This variation in the conceptualisation of CS and its operationalisation has led to questions being asked as to whether it is foolhardy to force the same CS model upon all supervisees without considering the differences and variations in the care context (Cutcliffe 2005; Stevenson 2005). It should also be noted that the development and success of models is dependent on the appropriateness to the profession and its speciality and locality (Butterworth *et al.*1996; Fowler and Chevannes 1998; Scanlon and Weir 1997). Clinical supervision will continue to be viewed ambivalently whilst clinicians are unclear about its ambit and without this evidence base the introduction of CS will be hampered.

Learning from our mistakes via case studies in which CS was unsuccessfully introduced may be helpful according to Grant and Townend (2007) who posit the following two questions. The first, how can organisation and clinical supervision champions develop appropriate structures and processes to achieve a balance between time spent on effective clinical supervision and that engaged in clinical practice with clients? The second, how can the practice of clinical supervision be encouraged sensitively that takes into account the stresses of contemporary mental health nursing practice? If clinical supervision is needed, then it should be defined by the mental health nurses who will partake of it.

Finally, Rice and colleagues (2007) provide an extensive set of recommendations which may assist organisations and clinical supervision champions to develop sustainable contemporary, relevant and sustainable clinical supervision practises. Lynch and Happell (2008a, 2008b, 2008c) also present a model for the implementation of clinical supervision that considers the complex factors that are likely to influence the uptake of supervision, including organisational culture, leadership, education and training, sustainability and evaluation.

Conclusion

The rhetoric of excessive claims for CS in the face of acute mental health units characterised by pressure, urgency and chaos only serves to devalue a potentially useful process. Ad hoc CS only serves to reinforce cautious attitudes towards supervision and supports the cultural belief that it has limited value in-practice. Nurses are more likely to pursue and persist with CS when a constructive environment is established that supports CS. Even though these findings were originally published in 2005, they resonate with current literature and the realities of present day practice. Given the substantive literature on this topic – is perhaps too much is being asked of this one process, especially in acute inpatient settings? CS will continue to be viewed with suspicion if its introduction is top-down and the orientation is that of quality control; or managers are allowed to pass themselves off as impartial confidantes and teachers. Acute care nurses have limited time and for them to commit to any process of supervision it must be meaningful, user friendly and relevant. As it stands, many nurses believe that CS has limited experiential value and are therefore cautious towards its wholesale adoption in practice. This culture will not be overcome easily. Further exploration of viable models consistent with the setting and the diverse needs of nurses are required.

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