The effectiveness of clinical supervision in nursing: an evidenced based literature review

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KEY WORDS

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ABSTRACT

Objective
Clinical supervision (CS) is attracting attention in the Australian nursing context with efforts underway to embed CS into mental health settings and to extend it to the general nursing population. The purpose of this paper is to review the available evidence regarding the effectiveness of CS in nursing practice in order to inform these efforts.

Method
Relevant literature was located by first accessing research articles in peer-reviewed publications that related to CS and nursing. A total of 32 articles were retrieved. In selecting articles for review, the following criteria were then applied: the article reported an evaluation of the effectiveness of CS; the participants in the study included qualified nurses (not students or generic health care workers); the approach to CS was clearly described; and, the method of data collection and analysis, either quantitative and/or qualitative, was explained in detail.

Results
Of the 32 studies identified in the literature 22 studies met the inclusion criteria. One feature that differentiated the studies was research method, for example, pre-post design; and, articles were initially grouped by method. The reported outcomes of the studies were then categorised according to Proctor's three functions of CS. The results of the studies demonstrated that all three functions, restorative, normative and formative, were evident. The restorative function was noted slightly more frequently than the other two functions.

Conclusions
There is research evidence to suggest that CS provides peer support and stress relief for nurses (restorative function) as well a means of promoting professional accountability (normative function) and skill and knowledge development (formative function).

INTRODUCTION

Currently in Australia, there are efforts underway to increase the use of clinical supervision (CS) in the nursing practice arena. There are signs that clinical supervision has been growing in the speciality of mental health nursing as evidenced by the establishment of standards set by the Australian and New Zealand College of Mental Heath Nurses (Winstanely and White 2002). Originally developed within the mental health care context and traditional psychotherapies (Yegdich 2001), CS is now being implemented for nurses in other clinical contexts. Whilst the practice of clinical supervision is established in other developed countries, such as the United Kingdom and the United States of America, at present it is underdeveloped in the Australian context.

The purpose of this paper is to review selected research studies that have focused on evaluating the effectiveness of CS in nursing. Available evidence about CS outcomes and effects has been accessed and analysed. The main purpose in presenting the review is to provide empirical evidence about CS, especially to inform those nurses who are considering its adoption or contemplating its continuation. As CS requires both fiscal and human resources to be sustained, evidence from the review can be used to offset uncritical adoption of CS or unrealistic expectations of its effects.

What is Clinical Supervision?

Clinical supervision is a process of professional support and learning in which nurses are assisted in developing their practice through regular discussion time with experienced and knowledgeable colleagues (Fowler 1996). During clinical supervision nurses employ the processes of reflection in order to identify and meet their need for professional development. The purpose of clinical supervision is to improve nursing practice and therefore needs to be focused on nurse-patient interaction (Van Ooijen 2000).

The primary cognitive process of clinical supervision is reflection, that is, thinking back on clinical experiences in order to recount them and deepen understanding and/or identify areas for further improvement. Reflection is particularly relevant to professional growth in a practice-based discipline such as nursing. That is, nursing knowledge is embedded in experience, and learning through experience is essential to the practice of professional nursing.

Clinical supervision enables nurses to discuss patient care in a safe, supportive environment. Through participation in CS nurses are able to provide feedback and input to their colleagues in an effort to increase understanding about clinical issues. In this sense CS is designed to serve a peer-educative function. The opportunity to discuss general issues in relation to patient care also opens a window of opportunity to develop consistent approaches toward individual patients and their families. In this sense, CS provides nurses with an opportunity to improve patient care in particular for a given patient and in general in relation to maintaining standards of care. In addition, CS provides an avenue for nurses to demonstrate active support for each other as professional colleagues. Through sharing and understanding they come to realise that they are 'not alone' in their feelings and perceptions, thus providing reassurance and validation.

The above description of CS is consistent with Proctor's functions of clinical supervision (Proctor, 1986). The functions are threefold; first is the formative function, an educative activity which was the original basis for CS; second is the normative function in the sense that clinical supervision enables the development of consistency of approach to patient care (ie follows 'norms' or standards of practice), third is a restorative function, which promotes validation and support for colleagues through peer feedback. Although presented as separate, the functions overlap and intersect in practice. As differentiated, they provide a useful organising schema for this literature review.

METHOD OF LITERATURE REVIEW

Clinical supervision in nursing was assessed through a systematic review of the nursing literature since

evaluative literature emerged in 1993. Searches of Medline, CINAHL, PsycINFO and Cochrane database were undertaken. The searches were limited to reports of research published in peer-reviewed journals. Studies were selected for review on the following basis: the article was an evaluation of the effectiveness of CS; the participants were qualified nurses (not students); the approach to CS was clearly described; and, the method of data collection and analysis included either quantitative and qualitative data, or both. There were no other restrictions in terms of setting, clinical speciality or whether CS was undertaken in a group or a one to one basis.

RESULTS

A total of 32 articles were initially located: of those studies, 22 met the criteria for inclusion in this research. Studies were first grouped by three different types of research design; four studies were considered to be comparative, three were pre-post evaluation studies and fifteen were post-only evaluation studies. Therefore in the majority of studies, CS was evaluated after it had been implemented. There maybe several reasons for this: first, is the lack of a well-validated and reliable measures of CS effectiveness; second, in nursing there is strong interest in qualitative research and in addition, there is a lack of funding for well-designed trials of CS; and finally, the opportunistic nature of post evaluation. Sample sizes varied and ranged from 10 to 660 in one of the post survey evaluations (Magnusson et al 2002). Mental health nurses and aged care nurses are dominant in the samples studied.

Table 1: Reported Outcomes categorised to Proctor's model

Normative: Professional accountability		
Change of action	Professional identity	Risk taking
Moral sensitivity	Confirming uniqueness of role	Job satisfaction
Problem solving	Change organisation of nursing care	Professional solidarity
Commitment affirmation	Improve individual's nursing care	Confirmation of nursing interventions
Confirmation of actions and role	Critiquing practice	Nurse patient cooperation
Identify solutions	Improving practice	Less patient resistance
Improve nursing practice		Improve patient relationship
Increase understanding of professional issues		
Formative: Skill and knowledge development		
New learning	Competence and creativity	Improved idea time
Improved knowledge	Professional development	Idea support
Professional development (deeper knowledge)	Confirming patient uniqueness	Creativity and innovation
Self confidence	Gaining knowledge	Communication skills
Self-awareness of thoughts and feelings	Competence	
Improved knowledge of human rights	Trust in self	
Recognizing family needs more	Knowledge	
	Insight into therapeutic use of self when relating to patients	
Restorative: Colleague/social support		
Listening and being supportive	Lower perceived anxiety	Improved relationship with nurses
Improved coping at work	Understanding colleagues	Trust
Accessing support	Increased interest	Reduced conflict
Better relationship amongst staff	Relief (discuss thoughts and feelings)	Reduced tedium
Engagement in the workplace	Relief of thoughts and feelings	Reduced burnout
Safe group environment	Empathy	Personal accomplishment
Sense of security	Sense of community	Personal development
Satisfaction with nurses	Catharsis	Coping
	Self understanding	

The selected studies were grouped into three types: comparative studies in which CS was implemented at one site, with pre test and post test measures obtained at that site and matched site (in clinical terms); pre test and post test evaluation studies in which CS was introduced as an intervention without comparison to a control group; and, post evaluation studies in which participants were asked to appraise their experiences of CS. The outcomes of the studies were recorded and then categorised in relationship to Proctor's (1986) three-function model of CS. Terms used to describe the outcomes of the studies were grouped according to Proctor's functions and listed in table 1. Reported outcomes of the studies were then categorised according to Proctor's (1986) model and are shown in table 2 (comparative studies), table 3 (pre-post test studies), and table 4 (post evaluation studies).

Table 2: Comparative Studies

Author	Type of CS and sample	Other intervention	Focus of study	Outcomes*		
				N[1]	F[2]	R[3]
Berg et al (1994)	n = 19 experimental ward, n = 20 control ward, nurses working in residential dementia care Supervision focused on one patient at a time, patients history described, nurses spoke of emotions evoked in themselves and they pointed out difficulties they have experienced CS group met every third week during the first 6 months, and then every fortnight in the next 6 months, each session lasted 2 hours	2 day course on dementia care, plus another 2 days during the year Individualised care	Burnout, tedium and creativity of working climate		x	x
Edberg et al (1996)	n = 20 control group, n = 19 intervention group, registered nurses in dementia care Group discussion focusing on feelings and reflections about residents and their experiences, as a basis for the provision of individualised care CS group met x 2 hours every third week during the first semester, then every fortnight in the next semester. CS lasted for 12 months	Individualised care 2 day training session on dementia care	Morning care observations with evaluation of nurse-patient cooperation	x		x
Hallberg and Norberg (1993)	n = 19 experimental ward, n = 19 control ward, aged care nurses in dementia care CS group focused on emotional reactions, reflections of primary and secondary appraisal of harmful situations CS group met x 2 hours every third week during the first 6 months, then every fortnight in the next 6 months, for a total of 30 hours Individualised care planning group discussion 2 hrs per week for a total of 34 hours	2 day course on dementia care Individualised care	Strain in nursing care scale, and emotional reactions in nursing care scale	x		
Palsson et al (1996)	n = 21 experimental group, n = 12 comparison group, sample were district nurses CS group met every 2 to 4 weeks, for 1.5 hours up to 34 hours in total	None	Karolinska scale of personality, burnout measure, empathy construct scale, sense of coherence scale	x	x	x

*Outcomes = according to Proctors model
[1]N=normative; [2]F=formative; [3]R=restorative

Table 3: Pre-Post Studies

Author	Type of CS and sample	Other intervention	Focus of study (outcome measures)	Outcomes* N[1]	F[2]	R[3]
Berg and Hallberg, (1999)	n = 22 psychiatric nurses CS group met x 2 hours every fortnight for 1 year for a total of 56 hours Individualised care planning group discussion 2 hrs per week for a total of 34 hours	Individualised care	Sense of coherence scale, creative climate questionnaire, work-related strain inventory, satisfaction with nursing care and work questionnaire		x	x
Begat et al (1997)	n = 34 registered and licensed practical nurses in medical wards CS group to individualise care and implement a primary nursing model to move from collective to personal responsibility Groups of 5 nurses met 1.5 hours per week for one year for a total of 75 hrs	Introduce a primary nursing model, which centralises knowing the patient	Nurses' satisfaction with working milieu, questionnaire regarding psychosocial environment of ward, nurses' views of CS through questionnaire at baseline and at 9 months		x	x
Segesten (1993)	n = 21 in two orthopaedic wards Group supervision to assist with role confusion following introduction of a modified primary nursing system. CS discussion about responsibilities, delegation, quality of nursing care, improving care plans and documentation, problems with physician cooperation, and working with the terminally ill CS group met x 2.5 hours every fortnight for 4 months, with two different supervisors, for a total of 34 hours	Introduction of a modified primary nursing system (nurses working as a team for a group of patients)	Questionnaire included nurses' self description completed before and after CS	x		x

*Outcomes = according to Proctors model
[1]N=normative; [2]F=formative; [3]R=restorative

Table 4: Post Studies

Author	Type of CS and sample	Other intervention	Focus of study	Outcomes* N[1]	F[2]	R[3]
Arvidsson et al (2001)	n = 10 psychiatric nurses Group discussion, using narratives, provided pedagogical and supportive method for reflection on nursing care CS group met fortnightly for 2 hours, for a total of 32 hours supervision	None	Phenomenological interviews two years after CS implementation		x	x
Berg and Welander Hansson (2000)	n = 13 dementia care nurses Group CS nurses discussed individual patients, nurses feelings and emotions discussed; session ended with a decision on how to provide further care 2 hour sessions every third week during the first 6 months, then every fortnight in the next 6 months, for a total of 30 hours	Education session on dementia Individualised care	Unstructured (prompts and points of clarification only) interviews focusing on nurses' experiences 9 months after implementation of CS Questionnaire on view of the effects of CS	x		x
Berggren and Severinsson (2000)	n = 15 registered nurses from 2 medical wards CS group discussion focused on analysis of care based on holistic caring model which places the nurse-patient relationship at the centre of care CS group (5 nurses per group) met x 1.5 hours every week for one year for a total of 75 hours	Introduction of a holistic nursing model of care	Interviews to determine the influence of CS on moral reasoning and clinical decision-making	x		

Table 4: Post Studies *continued...*

Author	Type of CS and sample	Other intervention	Focus of study	Outcomes*		
				N[1]	F[2]	R[3]
Bowles and Young (1999)	n = 201 registered nurses working in mental health care Mean experience ranged from 13.1 months to 30.7 months of CS Majority were one to one sessions with CS supervisors selected from outside own clinical area	None	11 Semi structured interviews to develop questionnaire 21 item questionnaire based on Proctor's functions	x	x	x
Hyrkäs (2005)	n = 569, mental health nurses CS view based on standardised Finnish understanding as systematic actions after vocational education, aimed at developing knowledge and skills, as well as supporting, clarifying and strengthening professional identity and practice	None	National survey Manchester CS scale Maslach Burnout Scale Minnesota Job Satisfaction scale	x	x	x
Hyrkäs and Paunonen-Ilmonen (2001)	n = 62 Multidisciplinary team/ group CS, including registered nurses, doctors, and all members of the health care team; the supervisors were all nurses CS group met x 1.5 hrs every 3rd week for x 3 years, for a total of 78 hours	None	Phenomenographic group interviews (CS teams) 4-6 months post CS implementation to explore how CS affected quality of care	x	x	
Hyrkäs et al (2002)	n = 10 supervisors, average experience of 15 years Group supervision in a multidisciplinary team with a focus on clarifying, collaborating and solving related problems; outside person as supervisor CS group met x 1.5 hrs every 3rd week for x 3 years, for a total of 78 hours	None	Semi-structured interviews based on guided conversation to gain supervisors' roles and perspectives on CS	x	x	
Hyrkäs et al (2005)	n = 32, first line nurse managers Group supervision, focus on how teams are built and work climate created, a nurse manager in a time of change CS 2 hours once a month for 32 hours in total	3 study days on team building and change	Empathy based stories were written by participants. Themes included leadership, communication skills, self development, self knowledge and coping		x	x
Jones (2003)	n = 10 registered nurses (hospice nurses) Group supervision support to encourage discussion about issues related to their professional practice CS 1 hour per week, over 12 weeks	None	N=5 purposive sample interviews and questionnaire to all the nurses n=10. Outcomes were interpersonal learning, identification, catharsis, family re-enactment, group cohesiveness, self understanding		x	x
Lantz and Severinsson (2001)	n = 8 ICU nurses CS as a form of support in stressful circumstances, based on reflection that integrates theoretical knowledge with practical experience Group CS x 2 hour for 10 sessions over 1 year, for a total of 20 hours	None	Interviews with participants using narratives of family interactions as illustrations of effects of CS on perception of family needs, role clarity, creativity and clarification of moral values	x	x	

Table 4: Post Studies *continued...*

Author	Type of CS and sample	Other intervention	Focus of study	Outcomes*		
				N[1]	F[2]	R[3]
Magnusson et al (2002)	n = 660, psychiatric nurses, district nurses, and mental health care workers, 50.9% who receive CS Types of supervision described as "process orientated supervision psychiatric care, clinical nursing supervision, psychotherapeutic supervision, other types of supervision, more than one type" (p.39)	None	Descriptive, correlational, cross-sectional survey, developed for the study, to determine ways in which clinical supervision enhances the nurses' ability to provide care by increasing confidence in their decision-making	x	x	x
Palsson et al (1994)	n = 23, district nurses and 9 cancer nurses CS group used case presentations to provide systematic support to nurses working in cancer care facing emotionally demanding situations CS ongoing x 1.5-2 hours every 2-4 weeks	Training program to increase awareness of how women handled breast cancer	Semi structured interviews - how did CS influence handling of difficult situations?	x	x	x
Severinsson and Kamaker (1999)	n = 158, general nurses Systematic clinical supervision conducted: "In a mentoring style that will encourage reflection of moral dilemmas and ethical decision-making" (p.83)	None	Questionnaire designed for this study which explored work environment, commitment to career, moral sensitivity and individual and organisational characteristics	x		x
Teasdale et al (2000)	n = 211, qualified general medical/ surgical nurses CS defined as: "having a meeting with a designated supervisor or a supervision group at least every 8 weeks to talk about issues arising from your clinical work" Critical incident: Details of a recent situation that they were sufficiently concerned about to have discussed in CS or within their informal support network	None	Managing critical incidents, burnout and perceived workplace support Questionnaires included the Maslach Burnout Inventory and Nursing in Context Questionnaire (developed for the study) Written reports of critical incidents, defined as a recent situation that created sufficient concern to have discussed in CS or within their informal support network			x
Walsh et al (2003)	n = 6, community mental health nurses, plus 1 leader Development of a model for CS that incorporated the necessary ingredients of safety, impartiality, support, trust and respect: CS group discussion focused on case review by one member each month; Rotated role of facilitator for each month Group met x 1.5 hrs each month for 6 months, for a total of 9 hours	None	Focus groups to clarify CS and develop a vision/model to establish group norms and process Questionnaire developed for the study, after 6 months to explore aims, adherence to norms, personal objective, supervision functions overall usefulness	x	x	X

*Outcomes = according to Proctors model

[1]N=normative; [2]F=formative; [3]R=restorative

DISCUSSION

Although the results of studies indicate that all three of Proctor's functions are evident as outcomes of CS, the restorative functions are reported marginally more often. In part this is a reflection of study design and outcome measures. That is, when only burnout and tedium were measured in relation to CS then only restorative outcomes are possible. Nevertheless, in studies where outcomes were open-ended, for

example through unstructured interviews (Ardvidsson et al 2001; Berg et al 2000) the results indicate that the restorative nature of CS still predominates. In light of the fact that the origins of CS were formative, the results may serve to reinforce the stressful nature of nursing work and the subsequent need for colleague support.

The Restorative

Since the inception of CS in the psychotherapies, the notion of managing emotional response to patient care has been paramount. Understanding the self through exploring emotions evoked by patients and the outward expression of emotion has been identified as being a critical part of development as a therapist. Given this history of CS the focus of its evaluation has centred on measuring the intensity of emotional labour. Considerable use of stress related measures of human behaviour are spread throughout the literature, in turn delivering a strong sense and support of the restorative effects of CS. The concepts of being able to ventilate ones own thoughts and feelings; reduce levels of anxiety and conflict; develop better interpersonal relationships; and improve coping ability are identified in the CS literature. These ideas are also identified in the effects of counselling therapies such as Egan (1990), Rogers (1951) and Corey (1991). Carl Rogers, whose work forms the basis of nursing humanistic philosophies, stressed the need for the counsellor to become a fully functioning human being. Whilst the benefits of ventilating ones thoughts and emotions have been reported to be effective, the CS process is not too dissimilar to debriefing which has received some criticism (Rose et al 2001).

The Normative

The normative component attempts to develop strategies to manage the professional accountability and quality issues in nursing. The themes that emerge in the normative outcome such as changing organisation of care, confirmation of nursing interventions, problem solving, and improving and confirming practice may lead to changes in how nursing care is delivered. Developing a stronger sense of professional identity and job satisfaction has been associated with improvements in stress and burnout in other industries (Murphy 1996). The quality activities generated from or undertaken in CS may lead to greater patient safety and better patient outcomes, although formal studies of patient outcomes in relation to CS are lacking.

The Formative

The Formative or skill and knowledge development area of CS is well documented in the outcome literature although marginally less than the other domains. The primary outcomes in this domain are knowledge increase and notions of increased self-awareness, creation and innovation. The formative component has been associated with years of nursing experience. Bowles and Young (1999) found that less years of nursing experience was associated with a higher rating of the formative domain being dominant in CS.

Study Limitations

The study was not inclusive of all studies of CS, as some did not meet the criteria for this review. Some of the outcomes in unpublished works and conference reports offer more support for CS. The interpretation of the outcomes of the studies and their relationship to Proctors (1986) model may be biased from the authors understanding and reading of the literature.

CONCLUSION

Considerable evidence for CS in nursing exists in the literature and there is sufficient empirical argument for CS to be implemented in nursing. Evidence exists around the three core domains of Proctors model of CS, providing peer support and stress relief for nurses (restorative function), as well as a means of promoting professional accountability (normative function), and skill and knowledge development (formative function). The nursing literature dominates with speciality groups such as mental health nurses and aged care nurses. More research is needed to evaluate the effectiveness of CS in other specialties of nursing. Further study needs to explore the differences between similar forms of supervision, such as action learning sets and mentorship groups.

Future studies should also focus on the relationship between patient outcomes and CS.

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