Clinical Supervision for General Nurses in NZ: The Imperative of Finding a Way Forward

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Nurses Perceptions of Professional/Clinical Supervision

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by any other person nor material which to substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements."

Signed:

Date:

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Abstract

Clinical supervision is a relatively new concept within nursing in New Zealand and there has been little research on the topic to date. However, Scandinavian countries and the United Kingdom have led the way by providing research showing the benefits clinical supervision can have for both nurses and the patients for whom they care for.

Over a period of time conversations with medical and surgical nursing colleagues revealed diverse and concerning views, attitudes and knowledge regarding clinical supervision. These encounters, attitudes and perceptions provided the impetus for this research. Initially the review will focus on two broad themes: firstly research that examines perceptions and attitudes of general nurses in all in-patient hospital settings towards clinical supervision and how they have found such support to be of benefit to themselves or their practice. Secondly it will focus on organisational documentation policies and procedures available to nurses in order to understand their contribution to nurses' understanding and valuing of clinical supervision.

The key questions this modified systematic literature review aims to answer is: what can research reveal about medical and surgical nurses' knowledge and attitudes towards clinical supervision? To what degree might nursing organisational and in-service education literature contribute to such perceptions, attitudes and knowledge? Is there evidence that indicates medical and surgical nurses who have received or learnt about clinical supervision develop particular perceptions of clinical supervision? And, is there literature evidence that suggests other factors influence the provision of, or access to, clinical supervision by general nurses that in turn influences attitudes and perceptions?

Chapter One: Introduction and Overview

"In clinical supervision we can be helped first to become aware of our thoughts and feelings and then, through reflection, 'clean' them so that we can see what is outside the window. Now, I know that windows have the habit of getting dirty again. I also know that the only thing to do about it is clean them again, since the cleaner the window, the clearer the view" (van Ooijen, 2003, p.1).

To me this model explains the essence of clinical supervision and what it brings to clinical supervision as well as showing the benefits it can have. Before learning about clinical supervision I knew nothing of it and it appeared to me that it was only accessible to nurses who worked under the umbrella of mental health. Now that I am aware of what clinical supervision is and what it can bring to nursing it makes me very annoyed that nurses within the general nursing population are not given the opportunity to partake or know of it. As nurses are one of the largest working populations within the healthcare system it seems unreasonable that this group is not given this opportunity. What concerns me even more is that some nurses who could benefit from clinical supervision have expressed a lack of knowledge about it or have negative perceptions of it though it has been identified as a meaningful way to promote reflection on practice and grow in confidence. Does this mean that there needs to be a tragic event in the nursing context for clinical supervision to be implemented like the Allitt enquiry in the 1990s?[1]

Clinical supervision is known as a formal process where nurses are guided by a colleague, peer, or an appropriate professional to reflect on their practice. This usually happens in a supportive environment and is intended to maintain the competence of a registered nurse. This modified systematic literature

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[1] In 1991 Allitt who was a nurse murdered four children and attempted to murder eight others under her care at Grantham and Kesteven hospitals in the United Kingdom. The Allitt enquiry drew concern from the public in regards to limited protection for vulnerable patients. Clinical supervision was identified as a support system that could increase vigilance and observations of staff (Lynch, Happell, Sharrock, 2007).

review is about nurses who work within hospitals and examines their perceptions and experiences of clinical supervision. It is also about the need for registered nurses to have support and develop their clinical competence to provide beneficial and effective care to the patients they look after. This chapter will provide the background and motivation for performing this modified systematic literature review by presenting an overview of the scope of practice for a registered nurse working within the hospital system and the place for clinical supervision within this setting.

The main focus of this dissertation is to provide a comprehensive modified systematic literature review of nurses' perceptions of clinical supervision and evidence that indicates benefit to their practice. This literature review will analyse the research to identify whether it will be of benefit to practice and should be acknowledged as a way of dealing with issues that arise in practice. Undertaking this modified systematic literature review will determine if there have been any recent developments in clinical supervision and whether there are any benefits for nurses participating in clinical supervision. Thus this review will deepen understanding of the important multiple contributions clinical supervision can make to nursing practice in medical and surgical settings.

The Aim of the Study

The question in this study is "What are hospital based nurses' perceptions and experiences of clinical supervision? The intention is to describe what registered nurses perceptions and experiences have been of clinical supervision within the hospital setting using a systematic literature review to provide the evidence for the need for clinical supervision in this setting. Currently there is limited research on clinical supervision within New Zealand and to date there is limited research on nurse's perceptions of clinical supervision pertinent to this setting. It is evident that nurses working in general medical and surgical settings are still a little suspicious of clinical supervision, mostly due to having a lack of understanding.

Cochrane states that "Supervision is not a chat, it is not counselling or therapy. It is purposeful and offers the nurse the opportunity to reflect on what is impacting on their nursing practice, e.g. relationships with colleagues or the wider context within which they work. It can help nurses develop professionally, to improve their interpersonal skills, to talk through a difficult practice situation, to become more conscious of individual and/or group behaviours" (Cochrane, 2012, p.30).

Background to Study

This study originated from my own experience of working within a busy acute surgical hospital setting where I had to work with people from different cultures, beliefs and environments which only added to the emotional demand of nursing. Nurses were often faced with traumatic situations as well as having to cope with increasing patient turn-over. Some reviews (McVicar 2003; Michie & Williams 2003; Zangaro & Soeken 2007) have shown that the main sources of distress in the workplace have been from associated job satisfaction, stress and burnout in nursing. As well as working long hours, being overloaded with work, having increased pressure, a lack of control over work, lack of participation in decision making, and professional conflicts. Quality of care given to patients has become more important to job satisfaction for nurses than ever before, with new interest being placed on nurses' 'moral stress' (Koivu, Hyrkas & Saarinen, 2011).

Our largest professional body the New Zealand Nurses Organisation (NZNO) states (2011, p.2):

> *"Nurses in Aotearoa New Zealand face a set of challenges that are unprecedented in the history of the profession in this country. New technology, a growing population, an ageing nursing workforce, new treatment modalities, genetics, and the local and global context of health care are merging within a context of constant restructuring, a tightening economic climate, and nursing workforce variability."*

With all these challenges coming to light there clearly appears to be a need for clinical supervision as nurses are required to do more and cope with the resources they have within their working context.

A Pivotal Study Experience

While working in a busy surgical in-patient arena I undertook a postgraduate paper on clinical supervision and became interested in how it could be implemented for nurses working in general medical and surgical areas of the hospital. At the outset of the study I found there were numerous articles in relation to Mental Health Nursing. Clinical supervision has been beneficial for nurses working in mental health, oncology and hospice settings. It has improved patient care, reduced rates of errors, improved efficiency, enhanced staff performance and reduced burnout (Berg et al.1994; Edberg et al.1996; Hallberg & Norberg, 1993; Berg & Hallberg, 1999; Begat, Severinsson & Berggren, 1997; Berggren & Severinsson, 2000; Jones, 2003; Palsson et al., 1994 & Walsh, et al., 2003). Other benefits claimed for staff were improved job satisfaction, enhanced integration of theory and practical knowledge, and increased confidence, self esteem and empathy. Clinical supervision has been defined in earlier years as a process that enables practitioners to have support and develop their competence and knowledge through reflection and exploration of scenarios or situations they may be faced with in practice (Department of Health, 1993). It facilitates reflective practice and encourages nurses to review and improve practice (Cleary & Freeman, 2005). Nurses also have the opportunity to discuss challenging issues encountered in practice and have the opportunity for feedback and validation from colleagues allowing them to improve patient care. It is also claimed to enhance personal development and emotional stability (Cleary & Freeman, 2005).

Although professional supervision has limited research specifically in relation to surgical or medical nurses when compared with mental health, benefits are claimed to be appropriate to nurses in all hospital settings (Cleary & Freeman, 2005). Nurses working in inpatient settings are often placed under

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heavy demands because of requirements to manage acute and chronically ill patients as well as coping with ever-increasing patient turn-over rates. Clinical supervision therefore provides the opportunity for staff to reflect on their practice and develop a consensual view of optimum standards (Cleary & Freeman, 2005).

Personal Observations of Colleagues Experience

Anecdotally colleagues I have worked with in surgical areas in Wellington have reported diverse attitudes towards clinical supervision ranging from enthusiastic desire to have access to regular supervision, to unconditional dismissal of its need or importance. This negative end of the spectrum is often accompanied by suspicion regarding its safety or lack of understanding regarding its intended purpose. In my experience it has not been accessible to all nursing staff. Some reasons for this could be that it is not a priority in the nursing services, there is insufficient funding for nurses to attend supervision, it is logistically difficult to allocate time for supervision, and there is confusion over what clinical supervision is. Other reasons could be that the perception of clinical supervision is seen as a way of monitoring or correcting practice, even though it has been argued that clinical supervision is 'protected time' to discuss sensitive or confidential issues and can lead to decreased stress levels. Nurses at Hutt Valley DHB who are working within in-patient areas report having little knowledge of what professional supervision is and often associate it with negative connotations. This can discourage nurses from seeking clinical supervision. Therefore this research will ascertain the extent of negative perceptions within the literature and whether other DHBs or hospitals have professional supervision available for nurses working in in-patient settings.

From this overview I concluded that there was sufficient evidence of the need for clinical supervision to be accessible within the in-patient hospital setting. However, as there is little research to date from a New Zealand perspective on ascertaining the value of incorporating clinical supervision into practice,

this study provided the opportunity to seek some answers to the question: What are medical and surgical nurses' attitudes to and perceptions of clinical supervision?

Clinical Supervision: Definitions

There is more and more literature available now on clinical supervision with each author claiming to have a definition of clinical supervision. In this section I will identify different definitions of clinical supervision which will help to gain a better understanding of the concept. Often these definitions can have very different meanings.

Hess (1980) explains clinical supervision as a quintessential interpersonal interaction where the supervisor meets with another (the supervisee) to make an effort to improve the supervisees relationship in caring for people the supervisee may come into contact with. This earlier definition reflects the psychodynamic origins of clinical supervision, when supervision was structured through intense therapist-supervisor relationship. The supervisor's aim was to work through phenomena encountered by the supervisee in their relationships with their patients, such as feelings of aggression. They would work through this in a supervisory relationship model rather than a therapeutic one. Psychodynamic therapists regarded supervision as fundamental for ongoing practice. However, Faugier (1992) reported that supervision in psychotherapy was moving away from concentrating on therapy for the supervisee but instead involved education and evaluative elements. The definitions of clinical supervision in nursing have also become more generic (Winstanley & White, 2003).

Platt-Koch (1986, p.7), asserts that, " many nurses may have misconceptions about the nature of clinical supervision and may be depriving themselves of one of the most valuable tools in existence for learning and refining skills of assessment, diagnosis and treatment of patients". Platt-Koch sees clinical

supervision as a way of expanding the therapist's knowledge base, assisting with clinical proficiency and developing the practitioners' autonomy.

Butterworth and Faugier (1992) define clinical supervision as the exchange between professionals about practice. This has been one of the most quoted definitions in the literature. It describes any nursing collegial contact and is therefore not helpful in increasing one's understanding of the process.

Bishop (1998) defines clinical supervision as a designated interaction between two or more professionals to ensure quality of care, within a safe environment, enabling a continuum of reflection and critical analysis. Authors such as Bond and Holland (1998) state that there is no widely accepted definition, however they support any definition that emphasises; support, education and assurance within a clinical supervision relationship.

The term supervision came from industry, where work had to be done according to policies and procedures within the workplace. This can be interpreted as a very top-down approach to work. In the late 1980s early 1990s the United Kingdom became interested in the concept of clinical supervision after the reorganisation of the health services, political influence and the acceptance of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) as a way of supporting and developing the future of nursing. There was a change in practice from task orientated nursing to a more holistic approach, which evoked the use of clinical supervision as a way of supporting nurses within this holistic paradigm. The holistic approach focussed on nurse-patient relationships, including; empathy, genuine, mutual respect and participation. The UKCC, a leading force of clinical supervision in Britain, gives the following definition:

> *Clinical supervision is a necessary process based on a clinically focused professional relationship between a practitioner and a supervisor. This relationship involves the supervisor using their clinical knowledge and experience to assist colleagues with development of their clinical skills,*

knowledge and values in order to promote and maintain high standards and innovation in clinical practice (1994, p.4).

It recognises that nurses need support as they have to deal with patients' psychology as well as their own.

As mentioned earlier Els van Ooijen, (2003, p.1) signifies clinical supervision as a metaphor;

"In clinical supervision we can be helped first to become aware of our thoughts and feelings and then, through reflection, 'clean' them so that we can see what is outside the window. Now, I know that windows have the habit of getting dirty again. I also know that the only thing to do about it is clean them again, since the cleaner the window, the clearer the view."

Clinical supervision can be interpreted as a formal process that offers nurses support, education, and a safe place to reflect on practices and determine how situations or processes could be improved. The Els van Ooijen model (2003) provides the supervisee with a chance to reflect on past events and determine how things could be changed or improved for the future.

All of these definitions support the idea that clinical supervision is an opportunity to have the support and education needed to grow personally and professionally as a practitioner. It is important that nurses gain an understanding of clinical supervision and what it entails and that health organisations are also promoting the concept. Health organisations need to have knowledge of current literature and research to assist the implementation of clinical supervision into their organisation wisely. The Health Practitioners Competency Assurance Act (2003) has meant there is more recognition of the importance of workplace health and safety matters in New Zealand. This has also been incorporated into the New Zealand Nursing Council Competencies where nurses are required to reflect on their effectiveness of nursing care (Farrell, 2003). These guidelines thus require

nurses to reflect on their practice and in so doing gain deeper self-understanding and personal insight.

An Imported Concept for Nursing

Nursing has gone through many changes in New Zealand in how we care for our patients. In the 1950s the model of nursing care used was team nursing, where groups of nurses were allocated a group of patients. The nurses within the group would work together to plan, implement and evaluate the care for the group of patients that they were caring for. Since this time we have adopted a primary nursing and patient allocation model. Primary nursing evolved in the late 1960s early 1970s (Hayward, 2009). One nurse was allocated to a group of patients. It was the responsibility of this nurse to plan the care for these patients throughout their hospital stay. Continuity and adherence to the plan of care developed by this nurse was maintained even when the nurse was off duty. Since then nursing has had aspects of primary nursing and the patient allocation model. The patient allocation model meant nurses were delegated patients according to their skill level and expertise. This could change on a day-to-day basis and meant that if the patient deteriorated a nurse with the right skill mix and knowledge would be then be allocated to the patient instead (Hayward, 2009). With the changes in how we plan care for our patients it has meant that nurses are more isolated and autonomous in their practice. There has also been a stronger focus on the health practitioner reflecting on their practice and how they care for their patients. With this in mind there needs to be other avenues in nursing to support nurses with the changing environment and models of nursing that they work within.

Earlier authors such as Day (1925), Schmidt (1926), Newton (1952), Wolf (1941), Florence (1953), Freeman (1952), Hollis (1938) and Perrodin (1954), described clinical supervision as a 'new' idea that focussed on the democratic process of professional growth, its potentialities, being informal, building partnership and supportive (cited in Yegdich, 1999). It was designed not to be

authoritarian and revolve around the 'should' and 'must' do's. It was aimed to generate contribution, cooperation and teamwork. Although having these aspects in mind it took an administrative or clinical teaching approach and focussed on the leadership of the nurses at the time. Since then clinical supervision has evolved to focus on the practitioner being able to reflect on practice and grow personally to be autonomous and provide effective care for patients they care for (Yegdich, 1999).

Clinical Supervision: Historical Influences

Clinical supervision is a relatively new concept in New Zealand with a limited amount of relevant published literature. This modified systematic literature review has therefore included literature published in Australia, the United Kingdom and Scandinavian (Sweden, Norway and Finland) countries with acknowledgement to White and Winstanley, (2006) who evaluate the cost and resource implications for implementing clinical supervision in Australia and New Zealand in community and hospital based nursing. American nursing authors tend to have a broader scope of clinical supervision and often include models from psychotherapy or managerial perspectives. American nursing authors also commonly associate it with nursing students while they are on clinical placement (Cummins, 2009). Therefore to gain clarity for this modified systematic literature review, American opinion on clinical supervision will be minimal and if included will have a direct link to surgical and medical nurses being able to reflect on practice. Whereas Australia, United Kingdom and Scandinavian countries have a number of research articles pertinent to medical and surgical nurses up taking clinical supervision that share a common model of clinical supervision.

Clinical supervision had been addressed in English literature from the late 1980s and since this time has been under the evaluation of Butterworth, Bishop and Carson (1996). However, North American nursing scholars have been writing about this since the early 1950s. Yegdich and Cushing (1998) suggest British counterparts have ignored their research. This highlights the

confusion surrounding clinical supervision. There are also different approaches to implementing clinical supervision. Ranging from a 'top-down' approach from managers to involving the supervisee's in the preparatory phase. This is of relevance to nursing practice as there needs to be a formalised implementation of clinical supervision. It has been found that when clinical supervision is organised it helps to build effective working relationships whereas if the boundaries are unclear this can compromise the implementation of clinical supervision and therefore be detrimental to clinical practice (Jones, 2006; Price & Chalker, 2000).

In the 1930s a programme of clinical supervision was endorsed in a text by North American authors (Schmidt 1926 and Burton 1930), which had followed on from a conference on clinical supervision held in New York. The conference attracted 367 nurses from 61 hospitals in North America at the time which indicates there was an interest for clinical supervision and for changes to happen within nursing (Yegdich, 1999).

An important text also evolved titled, Nursing Supervision (Perrodin 1954, cited in Yegdich, 1999). This writer emphasised the 'age of supervision' and it was hoped it would help alleviate the current crisis of the nursing service (Yegdich, 1999). There had been advances in medical and public health sciences which were threatening to separate the nurse patient relationship. Some authors were influenced by modern supervisory practices, education, or both, and psychoanalysis due to Freud becoming 'world famous' at the time. There were difficulties in defining supervision and often it would be met with suspicion and antagonism. Yegdich (1999) explains there is a need for clinical supervision to be differentiated from other forms of support, clinical teaching, performance review, organisational accountability and personal development. She agrees, and supports the idea that the modern supervisor of nurses needs to help the nurse (Day 1925, cited in Yegdich, 1999, p. 1197):

> ….to develop and express high ideas of her own than merely accepting
> those of the supervisor. The newer supervision also recognises the

importance of the creative tendencies in human nature and gives each worker every opportunity to express his (sic) creative ability. (Supervisor and supervisee) stand or fall together. Both are responsible for whatever success or failure comes to either one.

Authors such as Schmidt (1926), Hollis (1938) and Freeman (1952) go further to discuss clinical supervision from a managerial perspective which can often receive negative connotations such as 'overseeing' as a type of higher vision or the emerging theme of 'super' 'vision' (cited in Yegdich, 1999). Supervision in this instance was implemented with a managerial perspective and often the supervisee did not feel comfortable to talk about work related situations as they felt they were being assessed or watched within their practice. The overall aim was for supervision to achieve patient, administrative and public satisfaction within a democratic learning environment. While these concepts are applied to all specialities of nursing it has been continued in American scholarship and psychiatric nursing (Yegdich, 1999). Supervision in this context has been adapted from psychotherapy counselling areas and psychoanalytic methods (Yegdich, 1999).

In comparison, clinical supervision in the United Kingdom has been designed to support the nurse-patient relationship. While many definitions have been developed, the one most often used refers to an exchange between practicing professionals to enable the development of professional skills (Butterworth, 1992). United Kingdom authors have also found that there is a difficulty in distinguishing what supervision is and what models and modes it implements. In the context of the Allitt inquiry, it was identified that there needed to be better staffing, better organisation of the ward environment and regular review of the policies and procedures, closer observation of the proper procedures and access to an experienced practitioner who would also supervise clinical standards. All of these concepts relate to managerial supervision (Yegdich, 1999). Yegdich (1999) states that clinical supervision in the Allitt inquiry would not have prevented the outcome, as it relies on the

individual giving self-report. If there had been managerial supervision in place it would have highlighted the standards, professionalism, and delivery of care and determined if it was safe and accountable practice, but it is managerial supervision, nonetheless. Allitt was a nurse working in England during the late 1980s who murdered four young children in her care and harmed nine others. National policy at the time thought that if clinical supervision had been implemented it could have prevented such grave harm (White & Winstanley, 2006). As managers would have been able to monitor and make sure standards were maintained by Allitt even though it was viewed by Yegdich (1999) that she would not give a self reports of her practice. Due to this event clinical supervision was introduced nation wide to make it more accessible to nurses and allow managers to safeguard standards, develop practice and improve delivery of care (Yegdich, 1999). There was clearly a perception that if there was more managerial supervision in this instance, it may have prevented such as devastating outcome.

The texts from North America focused on bureaucratic supervisions primarily concerned with over-seeing activities, otherwise known as 'snooper-vision'. Butterworth strongly opposed this notion. Authors such as Wolsey and Leach (1997) argued that implementing managerial supervision would not only develop practitioners but also improve quality, levels of service and speed of service delivery as well as cut costs (cited Yegdich, 1999). Wolsey and Leach also advocate for the abandonment of psychotherapy models and favour the business of health care delivery. Giving the perception that clinical supervision is a way of management control and looking at patient care as a business proposal. This evolved in North America to incorporate psychotherapy models into supervision. Platt-Koch warned that if supervision was pursued in a managerial manner nurses would not partake. Furthermore the psychoanalytical model would only meet the needs of nurse therapists (Yegdich, 1999).

Counselling and Psychotherapy Origins

The concept of clinical supervision in the fields of psychotherapy and counselling was born out of the first meeting of the International Psychoanalytic Society held in Berlin in 1922. Eitington was fundamental in introducing clinical supervision into psychoanalytic training as early as 1925 (Lynch, Happell & Sharrock, 2007). Psychoanalytic training involved undertaking personal analysis, education by the way of seminars and lectures and having ongoing clinical supervision. Each part had a particular focus. During the personal analysis the supervisee discussed, explored and reflected on personal issues and responses to patients. The educative part was focussed on teaching theory and psychopathology. The focus of clinical supervision was understanding and interpreting what the patient was going through and then discussing the case in depth (Lynch et al. 2007).

In the field of psychotherapy authors often had debates in relation to the definition, aim, purpose and models of clinical supervision. The Hungarians represented by Kovacs (1936) and the Venetians by Bibring (1937) debated heavily whether clinical supervision was to teach or treat. Some psychoanalysts perceived clinical supervision as an alternate form of teaching, whilst other perceived it as a process of therapy. There is still no clear definition, aim, purpose or model that has been determined in psychotherapy (cited in Lynch et al. 2007).

Utilisation in Mental Health Nursing Contexts

Most research on clinical supervision has focussed on mental health or working in dementia care. Mental health has had a long tradition of clinical supervision; other disciplines have lacked a framework for professional development around emotions and complex relationships (Koivu, Saarinen & Hyrkas, 2011).

Professional supervision began in New Zealand in the 1980s with the administrative model, which involved a directive process and was primarily

undertaken by nurse managers as supervisors. It focussed largely on performance management and it was heavily criticised for not having any regard for the supervisee's professional development. In the late 1980s the psychotherapeutic model was embraced, which provided support to the supervisee (McKenna, Thom, Howard & Williams, 2010). More recently there has been a variety of models introduced which take into account the following concepts: administration, education and supervisory support functions. Clinical supervision in European countries and has had more of an administrative focus (McKenna, Thom, Howard & Williams, 2010).

In New Zealand where Maori are overly represented in mental health and addiction morbidity statistics, it is acknowledged there is a need to work with Maori health practitioners in the supervision process (Wepa, 2007). To address this there is a need for cultural supervision in the means of building knowledge of Maori cultural values, attitudes and behaviours to supply a supportive environment to manage complex issues and to ensure there is safe practice which is culturally sensitive. In this context, there needs to be a focus within clinical supervision where the individual practitioner is recognised as part of their wider 'iwi' group rather than being located within a European and more individualistic frame of reference (McKenna et al. 2010). Frameworks of supervision among Maori have been developed which have incorporated traditional supervision perspectives, the experiences of Maori supervisors and supervisees with the support of literature to weave a framework for tangata whenua supervision (Wepa, 2007).

Variable Utilisation in 'General' Nursing Contexts

Clinical supervision has been sporadically implemented, crisis driven or administrative (Koivu et al. 2011). This has been apparent in the United Kingdom, Australia and New Zealand. General nursing settings are cultures of action and management has treated clinical supervision as a luxury that has only been readily available to nurses working in senior roles. There are also misconceptions that clinical supervision is used in situations where there has

been poor performance or nurses are experiencing personal problems. These misconceptions are still prevalent today (Koivu et al. 2011).

There has been growing literature both qualitative and quantitative in medical and surgical areas (Koivu et al. 2011). The literature has shown some large scale research projects consisting of hospital and community based nursing settings in psychiatric as well as in general nursing specialities. There has also been a qualitative study in how clinical supervision may be beneficial in orthopaedic care, internal medicine, cancer care, and intensive care (Butterworth et al. 1997; Teasdale et al. 2001; Hyrkas et al. 2006).

When reviewing the literature it has been difficult to identify the difference in work on the medical and surgical units. This may effect the implementation of clinical supervision into these areas. Some distinctions have been made in that nurses felt that when working in an acute surgical setting it was fast pace, high turnover of patients, technical aspects of care and patients were more likely to progress and recover (Koivu et al. 2011). On the other end of the spectrum, nurses working in the medical arena felt it was complex, chaotic and violent. Nurses felt that working in this area allowed one to make a difference to patient outcome. Nurses learnt to hide their fears, disgust, grief, impatience and anger caused by their working environment. They are taught to take on a 'professional persona', be non-judgemental and to give the care required to their patients. Thus the aforementioned stressors placed on nurses in their place of employment often remain unresolved (Koivu et al. 2011). So, could clinical supervision be beneficial in these areas?

Chapter Two: Methodology and Method

This research is about surgical and medical nurses' experiences and perceptions of clinical supervision. This modified systematic literature review aims to critically examine literature and research in order to more fully understand the nature of nurses perceptions, knowledge and attitudes towards clinical supervision and what factors influence these perceptions. The method will involve reviewing the literature systematically and to critically collect and review a defined selected set of literature/studies utilising well justified questions (Sirola-Karvinen & Hyrkas, 2006). Chapter one provided an overview of the study and set the scene while chapter two will address the thematic methodology used in the research, including the rationale for this. A brief outline will be given on the foundations and theoretical perspectives of literature reviewing, which will support the rationale. The second part of this chapter discusses selection of literature, organisation and structure of analysis and strategies used to ensure rigour throughout the study.

Systematic literature reviews proceed in stages, starting with the research problem or question and defining the target group to the literature search, making sure all portions of the research topic are covered. The literature search is an important part of the literature review, requiring this phase to be carefully pre-planned. The quality criteria are defined in the research questions that guide the review and these may be refined during the research process (Hemingway & Brereton, 2009).

Systematic literature reviews are considered a reliable way of gathering the existing knowledge. The review may identify the need for further new research or eliminate unnecessary research initiatives. Every phase of the process is important and has a specific purpose which is systematically based on the previous phase. The aims of a literature review are to answer and present findings to initial research questions objectively, comprehensively and clearly (Hemingway & Brereton, 2009).

Philosophical Foundations of Literature Reviewing

Literature reviews are systematic, explicit and a reproducible method for identifying, evaluating and interpreting existing bodies of research that have been produced. They are important as they allow an understanding of the topic and what has already been researched, how it has been researched and what key issues have been identified or what needs to be researched further. Systematic literature reviews also place previous research in context and allows for comparisons to be made and provides a framework for further research. The researcher can also identify previous errors and avoid researching topics that have already been covered. It can also give insights into the researcher's topic which may be worthy of exploration (Baxter, Hughes & Tight, 2001).

Theoretical Elements of the Systematic Literature Review

It is important to be aware of the theoretical perspectives as they guide how people think and this includes how they structure their research. Theoretical perspectives guide which methods to use and shape or determine how to plan the topic under investigation (Kayrooz & Trevitt, 2005). Systematic literature reviews are a useful tool to promote knowledge of the research that is available. This can then determine what needs to be investigated further. Reviewing the current literature means that gaps in knowledge can be identified and it can also be clarified where no further research is needed. Systematic literature reviewing is a neutral process which is rational and standardised, allowing the reader to determine the objectives. Systematic literature review can sit within the scientific framework but is more identified with being qualitative and interpretive within the social sciences (Jesson, Matheson & Lacey, 2011).

Systematic literature review will identify the negative and the positive outcomes of available research and can also identify the strengths and the weakness of that research and help the researcher to articulate what may be

improved on or implemented into their own research. The researcher is also required to have a great knowledge of the topic including the explicit (from experience, research and evidence and from data statistics and information) and a tacit knowledge (peer learning, past insight, past experience and past reflection). This enables the researcher to draw on these two dimensions to interpret the work of others and through their own reflection (Jesson et al. 2011).

The systematic literature review process is focussed, comprehensive, and has a clear inclusion and assessment method. This helps to reduce the incidence of bias in the resulting meta-analysis. However, systematic literature reviews can be impacted by limited published information, and this may impact the conclusions the researcher draws from the data. Studies showing the positive effects of a treatment or process are more likely to be published than research that shows a negative outcome. It is important to identify the research that has been completed and what further research or developments need to be made in promoting the benefits and effects of clinical supervision for nurses and health organisations (Jesson et al. 2011).

A 'Modified' Literature Review: Rationale and Design

The method applied in a modified literature review is determined by the research questions/problems, type and quality of studies under review and the material and content in the studies. In this systematic literature review the sample sizes are small in the studies under review; therefore it is indicative that a modified systematic literature review will be conducted by synthesising the literature. There is also limited research available in regards to nurse's perceptions of clinical supervision, who work in medical and surgical settings (Sirola-Karvinen & Hyrkas, 2006). This involves analysing systematic reviews and bringing together findings of multiple qualitative studies. Systematic literature review has been considered a reliable way of collecting existing data (Sirola-Karvinen & Hyrkas, 2006). The approach is useful and helps to avoid biases and identify deficiencies in available

research. This in turn, highlights the need for further research or if research is unnecessary in the area being researched (Sirola-Karvinen & Hyrkas, 2006).

A thematic approach will be undertaken as it has proved to be a tried and tested method that preserves an explicit and transparent link between conclusions and the text of primary studies; it preserves principles that have traditionally been important to systematic reviewing (Jesson et al. 2011). The systematic review is an important method for evidence-informed policy and practice movement, which aims to bring research closer to decision-making. This type of review uses rigorous and explicit methods to bring together the results of primary research in order to provide reliable answers to particular questions (Jesson et al. 2011).

Selection of Literature

The material for this modified systematic literature review was found mainly on electronic databases through Cochrane, EBSCO, CINAHL, MEDLINE, psychINFO and Pub Med.

Inclusion	Exclusion
• Research studies published 1994-2012 due to limited amounts of research in this arena • The two main concepts are used in the text/content (general hospital nurses and professional/clinical supervision) • The focus of the study is on nurses perceptions of clinical supervision and the effects • The approach to clinical supervision is clearly described • Method of data collection and analysis is either quantitative or qualitative and is explained in detail • Dissertations and theses of university level or professional documents such as New Zealand Nurses Organisation, New Zealand Nursing Council, District Health Boards policies and procedures. Also documents of specific value and importance to the study.	• Research over ten year old, without specific significance • Only one or none of the key concepts were used in the study • The intervention in the study is something other than what is defined above and the target group is one other than nursing • The target group is mental health nurses • Research was not available or accessible through library services and • Overlapping research reports/articles.

Figure 1- Inclusion and Exclusion Criteria

The materials of this modified systematic literature review included one dissertation which was merited at university level. The total number of studies under review was 32 (please see the appendix page 61). The methods applied to these studies were: questionnaires, interviews, follow-ups and surveys. The research data was mainly collected from individual respondents and observations. Data was analysed using both qualitative and quantitative

methods. The number of respondents present in these studies varied from n=4 to n= 1918 (Sirola-Karvinen & Hyrkas, 2006). The studies researched dated from 1994-2012.

Also included in this modified systematic literature review is correspondence from New Zealand Nurses' Organisation (NZNO), New Zealand College of Nurses, and Nurse Entry to Practice Programme Coordinator's from Canterbury, Hutt Valley, Auckland and Capital and Coast District Health Boards (DHB's).

Organisation and Structure of the Analysis

In this research the data search and analysis proceeded through five stages:

(1) Specification of the research question: What can research reveal about medical and surgical nurses' knowledge and attitudes towards clinical supervision? To what degree might nursing organisational and nursing education literature contribute to such perceptions, attitudes and knowledge? Is there evidence that indicates medical and surgical nurses who have received or learnt about clinical supervision develop particular perceptions of clinical supervision? Fourthly; is there literature evidence that suggests other factors influence the provision of or access to clinical supervision by general nurses that in turn influences attitudes and perceptions?

(2) Planning of the systematic literature search and the databases under the search. This was performed by searching the electronic databases for the following key words; general hospital nurses and/or professional/clinical supervision. The PICO (population, intervention, comparison and outcome) search strategy was used as it groups keywords into thematic groups. PICO is often used in medical literature to search evidenced based literature and where systematic literature reviews are used commonly used (Sayers, 2008). The PICO search strategy was used as it identified the following: population being registered nurses, intervention being professional/clinical supervision,

comparison of no supervision or informal supports and outcome being if clinical supervision assisted perceptions or affected the nurse's practice. This strategy has been helpful in addressing the questions at the heart of this review.

(3) Implementation of the literature search electronically

(4) Selection and critical review of the material included in the review in relation to the following inclusion and exclusion criteria: The article needed to be an evaluation of nurses' perceptions of clinical supervision or the effects of supervision. The participants needed to be registered nurses who worked in hospitals. The method of data collection and analysis included either quantitative and qualitative data, or both. Also there were no other restrictions with the setting or whether clinical supervision is undertaken as a group or on a one to one basis.

(5) Analysis of the material and summarising the findings. A thematic synthesis approach was undertaken in five stages which incorporated: coding of text 'line-by-line', the development of themes, and the generation of analytical themes within the text in the results or findings of the article (Sirola-Karvinen & Hyrkas, 2006).

Pope et al. (2000), suggest data analysis is appropriate when policy development is an outcome of the research. They also found that it is useful when there are time limits to the actual research process, as the time constraints will influence the outcome of the research and future development of policy in clinical supervision in nursing (Farrell, 2003).

An analytic framework was found to be most appropriate for this study. It consists of five key stages (Lane, et al. 2001 p.54):

1. Familiarisation: reading and listening to the data

2. Identifying a thematic framework: identifying all the key issues, labelling   data into manageable chunks

3. Indexing: applying the thematic framework to all data

4. Charting: rearranging the data into themes. A spreadsheet was used for this (see page 61)

5. Mapping the interpretation: linking emergent themes to the original aims and questions and providing explanations for findings

Figure 2. Analysis of research

Pope et al. (2000) concluded that analysing qualitative data can often be complicated and time consuming and that using this analytic process makes it more explicit and informed (Farrell, 2003). The analytic framework as discussed by Pope et al. (2000) and Lane et al. (2001) offered a workable structure, which I used and adapted to guide the analytic data process.

The material gathered was organised and classified according to the themes or patterns that emerged. This also identified differences between professional supervision in the UK, Scandinavian countries and New Zealand. The policies or procedures were also analysed from different DHBs, NZNO and Nursing Council to see whether they supported clinical supervision in practice. The significance of such material is that it has real potential to influence nurse's perceptions of clinical supervision. For example the absence of overt mention or support for clinical supervision in general nursing contexts is very likely to contribute to nurses negative perceptions. The next step was to further analyse these categories by using a thematic framework.

Thematic Framework

The application of the thematic framework as discussed above was applied to the literature. I became immersed in literature regarding clinical supervision being used in the medical and surgical arenas. Often literature would also be reread to capture the main themes and issues within the text. This

constituted 'familiarisation'. I then looked for statements and findings that could be grouped under the following headings: ' Perceptions', 'Benefits', 'Experience', 'Barriers' and 'Influences from Organisations' as these related to the study questions and enabled the research to be specific to this context (Farrell, 2003). This helped to identify a thematic framework.

As statements and themes appeared, I began to make groupings into main themes and code them accordingly: 'P' for perceptions 'B' for benefits 'E' for experience 'Ba' for barriers and 'O' for influences from organisations. These themes were not specific and often over-lapped or were connected to each other. Every piece of research read was coded in this manner and then entered into a spreadsheet under these themes. This resulted in data being indexed (see appendix page 61). Once data had been coded in this way I was able to define further and move data around. This represented the charting phase of the process.

Finally I linked back to the research aims and questions, which focussed on finding out what nurses working within medical and surgical areas, knew of clinical supervision and what their perceptions were. The data was then further refined and four main themes emerged through the literature on medical and surgical nurses perceptions:

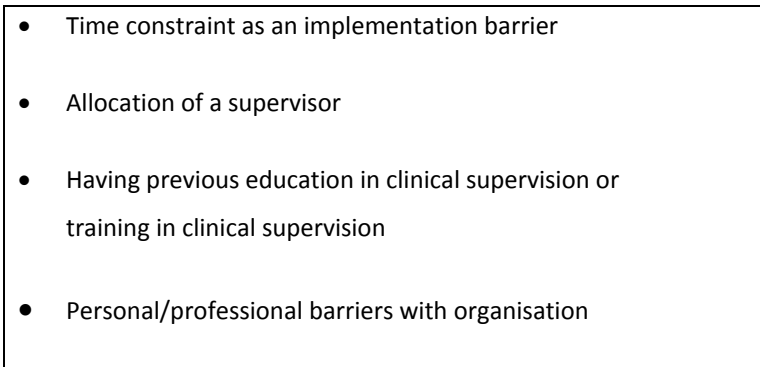- Time constraint as an implementation barrier

- Allocation of a supervisor

- Having previous education in clinical supervision or training in clinical supervision

- Personal/professional barriers with organisation

Figure 3. Medical and surgical nurses' perceptions

Thus the thematic analysis assisted in the data analysis in this modified systematic literature review, allowing me to stay close to the main themes

identified in the literature, which was the intention of this chosen methodology.

Chapter Three: Findings, Themes and Interpretations

Medical and Surgical Nurses' Perceptions

In this chapter, the findings found from reviewing the literature on surgical and medical nurses' experiences and perceptions are presented in four main themes that have emerged from the analysis. These four themes were determined from 32 articles reviewed (please see the appendix pg 63). The following themes were identified in the papers reviewed: time constraint as an implementation barrier, allocation of a supervisor, having previous education in clinical supervision or training in clinical supervision and personal or professional barriers with organisation. The papers reviewed identified these themes.

These four themes have been stated previously in figure 3 within the previous chapter and have emerged on a regular basis throughout the literature. It appears that these common themes have been identified in earlier literature in the 1990's and are still current within nursing today, specifically to nurses working in medical and surgical areas.

These four themes have emerged from using the thematic framework on literature that pertains to nurses working in medical and surgical units and has shown to impact the process of clinical supervision in these arenas. Keeping in mind the intention of this study I will stay close to the facts presented, meaning that each theme will be explained and be supported by quotations from the literature. Where necessary this will be further explained.

While these four themes have been helpful in problematic issues the various barriers to implementing clinical supervision don't always fit tidily within the structure of these four themes. Figure 4 on pg 36 demonstrates a range of barriers which impact on implementing clinical supervision within general medical and surgical hospital settings.

Time Constraint as an Implementation Barrier

Within this modified systematic literature review, time still remains one of the largest concerns when implementing clinical supervision. This has been a common theme in a lot of studies as participants find it hard to free up time to attend supervision and find that they often have to make an appointment to keep to their commitments (see Figure 4, page 36). Some of the participants in studies have had to use 'Do Not Disturb' signs or 'Interview in Progress' or went to the extent of locking themselves in a room so that they would not be disturbed. These methods show that participants wanted to go to the extent of protecting their time to have clinical supervision even if it was eventually violated. Some of the studies have also shown staff using their own time to have clinical supervision. Other barriers are the beliefs that if all nursing staff on the unit had supervision it would mean that some staff would miss out and patient care would be effected, as it is time the nurse is taken away from the clinical setting. Some nurses have been reported having to cancel supervision sessions due to increased work loads and sickness (Cummins, 2009; Kilcullen, 2007; White et al. 1998; Sexton-Bradshaw, 1999).

On the other hand, nurses' value this time as it gives them a chance to reflect and learn from practice. They can bring situations to clinical supervision and generate the conversation and know it is their time to discuss issues without thinking about the aspects of work as this is dedicated time for clinical supervision (Cross, Moore & Ockerby, 2010; Kilcullen, 2007). A recent study looked at the efficacy of clinical supervision and how this influenced job satisfaction, burnout and quality of care. It found that participants who found time for clinical supervision would score 1.6 times more in extrinsic, intrinsic and total job satisfaction categories of the Minnesota Job Satisfaction scale than those who did not have access to clinical supervision. It is, however, important to note here that this study was carried out in Finland across 12 different sites which had clinical supervision already established; the

response varied from 21 to 140 questionnaires in one organisation. It is possible that the supervisees who replied to this study had a positive experience with clinical supervision thus this representing a positive bias (Hyrkas, Appelqvist-Schmidlechner & Haataja, 2006).

Another positive has been supervisees being able to reach other group members and supervisors through using video-conferencing technology in the United Kingdom. This has reduced stress as well as the time involved in travelling to meet for clinical supervision (Marrow, Hollyoake, Hamer & Kenrick, 2002). With current shortages and changes in practice nurses need to be given the opportunity to develop practice. Video-conferencing has been achieved by using technology to reach nurses in other geographical areas. This has allowed further developments in patient care protocols and allowed collaboration between organisations (Marrow et al. 2002).

It is so important nurses get the time to have clinical supervision; with the changing working environment and the demands on nursing there is even more of a need for clinical supervision. Studies spoken about here have shown that there are ways of using time effectively by implementing supervision into a nurse's practice, using technology or using group supervision to get the best out of the time allocated. This would enable nursing staff to discuss matters without being restricted or having disruption and also allowing allocated time for reflection.
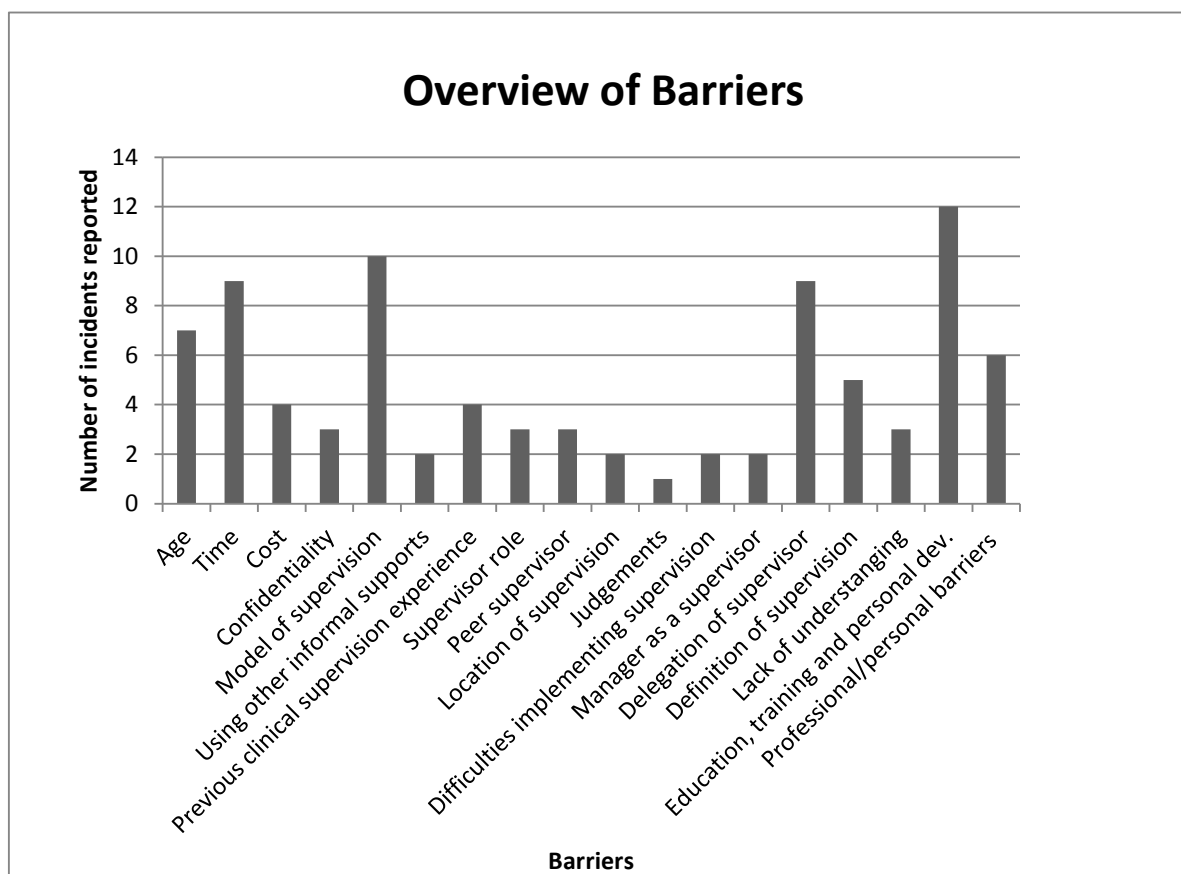
Overview of Barriers

Figure 4. Overview of Barriers

Allocation of a Supervisor

The New Zealand Nurses Organisation recognises the importance of clinical supervision and believes that the nurse or midwife should be able to choose their own qualified supervisor (NZNO, 2011). When looking at the literature a number of studies have followed this key component that NZNO has set for how clinical supervision should be arranged in New Zealand. Davey, Desousa, Robinson and Murrells (2006) looked at nurses qualified between 1997 and 1998. They examined the experiences of 1918 nurses, 18 months after they had gained their qualification in adult, child, disability and mental health nursing areas. They found that only 38% of nurses were receiving clinical supervision with mental health and learning disability nurses being more pro-active. The mental health and learning disability nurses had more than half receiving supervision with only 31% of the adult branch and 35% of the child

branch. In this modified systematic literature review it was identified that the supervision relationship is very important and that nurses receiving supervision from a peer of a higher grade that has been allocated to them as having a negative connotation. This research also identified that 42% of nurses working in mental health were able to choose their supervisor in comparison to only 12% in the learning disability group. These nursing groups were compared as they had similar amounts of nurses receiving clinical supervision. The groups that had supervisors allocated to them did not want further discussion about work situations with staff or patients and did not want further supervision on follow-up interviews (Davey et al. 2006).

As supervisee's prefer to choose their supervisor as this gives them comfort and they feel they can raise and explore issues or situations that happen in practice. They need this safe environment to be able to reflect on situations (Davey et al. 2006). One study looked at implementing supervision and how the roles of supervision effected clinical supervision. This study took place from 1997 to 2000 within an acute general hospital in Scotland in which 385 nurses worked at. It was identified within the study participants found it very important to choose their supervisor as this enabled quality of the relationship and for clinical supervision itself. Other themes identified in this study were the need for trust, confidence and to have the challenge to ascertain whether clinical supervision is worthwhile and should be sustained or not (Cerinus, 2005). The choice of a supervisor has been determined as important factor to help build relationships of trust. Where there was lack of choice nurses often viewed this as threatening, nurses with experience could reject this notion whereas nurses with less experience may accept it (Sexton-Bradshaw, 1999).

If clinical supervision is introduced in a 'top-down' manner nurses tend to resist it and do not want to be involved. As previously discussed in the Newham Hospital group this was how clinical supervision was introduced. They found that the ICU nurses did not accept it and it took much convincing

of the benefits to persuade nurses to partake (Price & Chalker, 2000).
Another study also took an unconstructive approach by pulling names out of
a hat to match the supervisee and supervisor. Although the supervisee's were
able to reject the person they were matched with. On reflection at the
interviews it was found that the participants had a satisfactory relationship,
although some participants identified issues such as being matched up with a
peer from the same work setting and found it hard to speak to them about
work and felt that since this colleague was in the same working arena
couldn't discuss issues identified with staff as this would be telling tales so to
speak. In this study it also wasn't uncommon for a supervisee to be matched
with a manager. This was suggested as developing change within the
organisation but it can also be viewed that clinical supervision was
hierarchical and managers wanted to control the supervision a supervisee
received and monitor their current practice (White et al. 1998). The United
Kingdom has made clear boundaries about the use of managers as
supervisors. They state clinical supervision is not a managerial control system.
Therefore it is not manager's responsibility or managerial supervision, is not a
form of performance review and is not hierarchical. This is echoed
throughout many European countries. In Finland it would be a contradiction
of the Ministry of Social Affairs and Health if head nurses or managers were
supervisors for their staff. Although the UKCC does advise that supervision
should be supported, evaluated and facilitated by managers (Cutcliffe &
Hyrkas, 2006).

Bush (2005) makes it clear that supervision is not hierarchical, a performance
review, management tool or a form of therapy. Nurses have the option to
choose who they would like to supervise them and supervisor also has a
choice whether they would supervise. Allowing there to be minimal tension
within the relationship and for the supervisee to gain the best possible
support and feel comfortable within the relationship. Since 2000 studies have
shown that nurses have more of an opportunity to choose their supervisors

and this seems to be the best way to build a trusting relationship where the supervisee can talk about their concerns in confide.

Previous Education and Training in Clinical Supervision

Previous education and training was mentioned in 12 of the 32 articles pertinent to these four themes. In the literature reviewed some participants would participate in preparatory days for the implementation of clinical supervision prior to commencing the research. This would involve learning about the model of supervision being implemented, the roles within supervision, forming ground rules and addressing timing of sessions and confidentiality, and opportunities to clarify any perceptions about the concept (Cross, Moore & Ockerby, 2010; Marrow, Hollyoake, Hamer & Kenrick, 2002; Cutcliffe & Hyrkas, 2006; Hyrkas, Appelqvist-Schmidlechner & Kivimaki, 2005; Begat, Severinsson & Berggren, 1997).

In one study conducted in Ireland nurses found the preparatory phase to be inadequate as it was not targeted for the general nursing population. Junior and more senior nurses were unfamiliar with clinical supervision so it was a new concept for them. They found that the workshops were in favour of how mental health nurses had clinical supervision and felt they were not able to question accordingly. Also the staff were new to the concept which made it extremely difficult (Kilcullen, 2007). A reason for not having an adequate preparatory phase could be that Ireland at the time had no formal system of clinical supervision and the researcher had to become familiar with clinical supervision from literature in the United Kingdom which was predominantly targeted for mental health nurses. Another research group wanting to implement clinical supervision into Newham General Hospital ICU setting, found that members had taken modules in reflective practice and clinical supervision but still felt they knew very little about it. Their main aim was to educate the working group with relevant literature, gaining help from the

university in association with the Trust which had already implemented clinical supervision. The implementation process was started using posters, flyers, letters, talks, group and individual discussion, teaching sessions and having a journal club. The research group identified that this preparatory phase needs to happen so that staff knew what to expect and where prepared for the clinical supervision sessions (Price & Chalker, 2000). As it has been found that supervisee's who have limited knowledge and experiences of clinical supervision and its benefits tend to give low evaluations of the concept (Sirola-Karvinen & Hyrkas, 2008).

White, Butterworth, Bishop, Carson, Jeacock & Clements (1998) identified that supervisors also have to have adequate education prior to supervision. Clinical supervision involves many hours of practice, as well as constructive feedback to be able to improve in giving supervision effectively to supervisee's. In the Newham General Hospital where clinical supervision was implemented there was an external facilitator who was a very valuable source for constructing supervision and developing supervisors. Despite the many hours of experience these supervisors had, they still were not confident in their role, and only offered supervision to individuals rather than groups (Price & Chalker, 2000). Training and education of supervisors and supervisees should be a major investment. As well as having ongoing workshops to provide opportunities for discussion and problems relating to clinical supervision (Marrow et al., 2002).

Some nurses had gone on to study clinical supervision in relation to nursing theory, group theory, general human development and models of supervision (Begat, Severinsson & Berggren, 1997; Berggren & Severinsson, 2003; Bondas, 2010). By doing further study in clinical supervision it reflected positive outcomes for the clinical supervision relationship and supervisees could develop and become more assertive by having an experienced clinical supervisor. A study in Finland by Hyrkas, Appelqvist-Schmidlechner and

Haataja (2006) found that clinical supervisors who had been educated in clinical supervision were more likely to score clinical supervision higher than those who had not. Research has emphasised the importance of having education for supervisors and supervisees as it influences the quality of clinical supervision (Butterworth, Carson, White, Jeacock, Clements & Bishop, 1997; Cutcliffe & Proctor, 1998; Hyrkas, et al. 2006).

Some of the research also showed that participants within the studies had undertaken supervision in the past (Bondas, 2010; Berggren & Severinsson, 2003; Sirola-Karvinen & Hyrkas, 2008; Hyrkas, et al. 2006; Cross et al. 2010). Twelve different research sites in Finland evaluated supervisees' responses to the Manchester Clinical Supervision Scale, Maslach Burnout Inventory, The Minnesota Job Satisfaction Scale and a Good Nursing Care Questionnaire. It was found that 77.6% of the participants had had prior experience of clinical supervision out of 799 participants. Of these participants, experience of clinical supervision was one of the predictors for high evaluations in clinical supervision. They found that supervisees who had more than 2 years of clinical supervision would give more positive results than supervisees who had had less than 1 year of clinical supervision (Hyrkas et al. 2006).

Personal/Professional Barriers with Organisation

It has been shown that health-care policy has had considerable influence on the development of clinical supervision in the UK. Often ideas around professional development can begin as good ideas and then wither on the vine if not written into policy. Clinical supervision has been used as a framework for the Department of Health for developing and supporting practice and has an influence on strategic planning from the Chief Nursing Officer. It was well supported in the policy 'Vision for the future' (1993) and it was identified that clinical supervision needed to be further developed and explored (Butterworth, Bishop & Carson, 1996).

Earlier studies such as Berg et al. (1994) agreed that the implementation of clinical supervision could help with coping with stress, both emotional and cognitive. They found clinical supervision increased creativity and feelings of accomplishment and decreased burnout and tedium in the workplace. This needed to be supported by work related social support to decrease the amount of strain and stress of the job. Organisations needed to have support systems in place to relieve work-related stress.

A small qualitative study was implemented into a Newham General Hospital ICU as issues of support and reflection in practice were identified. They found that in implementing clinical supervision, there needed to be a culture change among individuals as well as at management level. They found that the organisation needed to stay committed to allowing time and finances if clinical supervision was going to be developed. Clinical supervision group members are now discussing their experiences and processes of clinical supervision so that it can be implemented more smoothly throughout the hospital. The organisation has also given support by making clinical supervision an objective of the Trust and having a working party to determine whether further research into clinical supervision is effective (Price & Chalker, 2000). By having this culture change it was hoped existing staff would become familiar and recognise the benefits. The organisation also made an emphasis on clinical supervision being a voluntary process and so that it was not linked with management/appraisal systems. Earlier studies have also found that nurses commonly link supervision to performance reviews, personal therapy, management and preceptorship this therefore inhibits them attending clinical supervision. Other matters have also arisen such as management style lacks support of nursing staff to attend clinical supervision, leading to poor level of staff cover while nurses are attending clinical supervision therefore making it a liability, and threatening nurses future employment (White et al. 1998). Clinical supervision has often linked to

managerial control and nurses perceiving it as a means of monitoring, assessing and watching their practice (Butterworth & Faugier, 1998; Yegdich, 1999; Davey, Desousa, Robinson & Murrells, 2006). It was great to see that this organisation was making an effort to support the implementation, as it has been found that if the organisation supports clinical supervision it builds staff morale and strengthens work colleagues relationships (White et. al. 1998). Although Price and Chalker (2000) found in their research that there was resistance from ICU nurses if there was a top down approach and there had been a lack of involvement from those who were expected to benefit from the process. They were able to identify this factor and avoid this method in the future.

Other research considered the implications of cost of implementation versus the positive effect of clinical supervision on staff retention. It found that by implementing clinical supervision there was decreased amounts of sick leave, stress, absenteeism and maintenance of staff (Sexton-Bradshaw, 1999; White et al. 1998; Cummins, 2009; Berg, Hansson & Hallberg, 1994). Showing the benefits outweighed the cost and also giving a positive picture to staff within the organisation. One study conducted across Australia and New Zealand aimed to examine the costs of implementing a clinical supervision programme. The study involved 146 supervisees; 73% were female with half of the sample being registered nurses and the other half containing more senior clinical nursing staff. 53% of the sample worked within hospital settings with the rest working within community or a mixture of both settings. The aim of the programme implemented was for nursing staff to attend supervision monthly and have a session between 45 to 60 minutes in duration. This did vary within the study. They analysed the costs depending on what staff grade the supervisor was, length and frequency of the sessions. The cost of having clinical supervision was determined by the peer group who was the supervisor for the supervisee. This highlighted that it was effective to have clinical supervision by one's own peer group. The Manchester Clinical

Supervision subscale determined that by having clinical supervision with someone from your own peer group was significantly elevated in the Importance/Value subscale in comparison to nurses supervised by a member from another peer grouping. This research concluded that having supervision from a supervisor of your own peer group as one-one supervision cost about 1% of the nurses annual salary. Although this increased in cost depending on what grade the peers were from, time away from work and workload cover. An investment in clinical supervision showed to be effective on burnout and determined that cost should not impede clinical supervision being implemented and running clinical supervision programmes within any organisation. This research also highlighted that clinical nurse managers need to comprehend clinical supervision as becoming part of the nurses working milieu and not separate. When interpreted in this way 1% additional cost would be viewed as a small size of cap on nursing practice which would gain benefits for the future (White & Winstanley, 2006). Also if clinical supervision was viewed as a cost factor what impression or perception would this give to the nursing workforce?

While outside of this dissertation it is important to note that findings from a recent qualitative study in mental health suggested investment in quality clinical supervision will help to retain nurses and if health care organisations endeavour to make a cultural change towards the benefits of clinical supervision with new staff employed this will promote the change in perceived perceptions of clinical supervision (Lynch & Happell, 2009). These barriers covered here may impede clinical supervision being implemented nevertheless more and more literature is proving its potential benefits and it is becoming more acknowledged as a strategy to retain nursing staff (Cummins, 2009). Organisations can also learn from how clinical supervision has been implemented in mental health settings to promote its implementation for nurses working in inpatient medical-surgical units.

Reported Benefits for Nurses and Patient Care

Of all the research read for this systematic literature review all articles spoke of positive benefits of implementing clinical supervision (see figure 5 on page 46). The literature reviewed showed and this bar graph demonstrates there is sufficient evidence to argue that clinical supervision should be implemented into general nursing.

Clinical supervision is becoming more established, although the measurement of its effectiveness still proves to be a challenge. One of the largest studies undertaken in the world; The Clinical Supervision Evaluation Project which had 586 nurses participate in 23 centres over England and Scotland reaped many positive outcomes (Butterworth, Carson, Jeacock, White and Clements, 1999). Findings found that clinical supervision provides a provision of support, improved job satisfaction and reduced burnout levels. One internationally recognised tool used to evaluate clinical supervision is the Manchester Clinical Supervision Scale. This quantifies qualitative data. This scale has been used to quantify data in a study of 211 nurses in 11 chosen hospitals over one district in England (Cummins, 2009). The benefits were evaluated and found that clinical supervision gave valuable support to junior staff. It is also important to note that supervisors and supervisees need adequate preparation before clinical supervision as this assists in the benefits of having clinical supervision. Clinical supervision has had significant results for the patients nurses care for as well as professionally. In this study as well as other studies it has proven to reduce professional isolation, enable professional development, develop personal growth and enhance quality of patient care (Cummins, 2009). From the literature reviewed in this systematic literature review the benefits are identified in the graph below. It shows that clinical supervision enhanced reflection, nurses being supported, building skills and knowledge as well as building confidence and trust in relationships. From the literature reviewed for this systematic literature review clinical supervision

showed so many positive outcomes. Hospitals and organisations need to realise these and adopt or implement the concept of clinical supervision, because as previously discussed the benefits clearly out-weigh costs incurred.
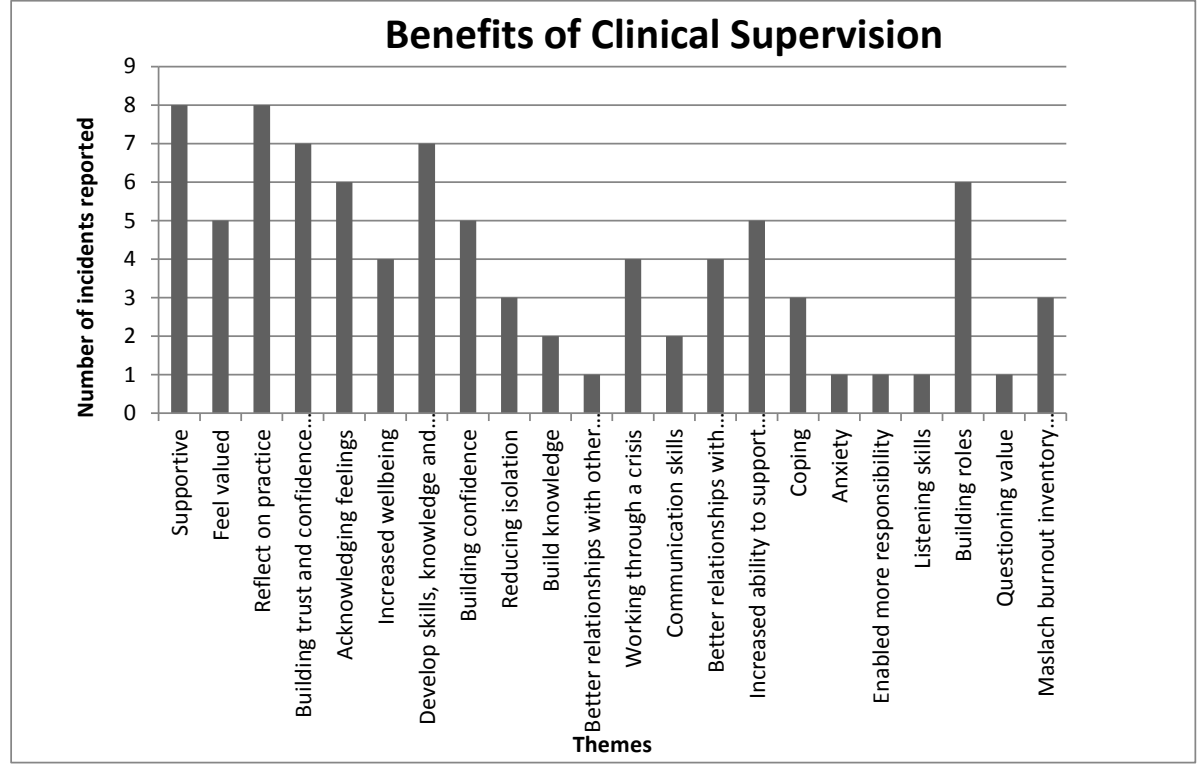

Benefits of Clinical Supervision

Figure 5. Benefits of Clinical Supervision

Influences from Organisational and Policy Documentation

This section is of importance as organisational and policy documentation can influence the uptake of clinical supervision within the health sector and also impact on the themes discussed. Currently, the New Zealand Nursing Council and New Zealand College of Nurses do not have a supporting document for clinical supervision for nurses working in general hospital settings. The New Zealand Nurses Organisation currently has a current position statement that supports nurses and midwifes having clinical or professional supervision. It recognises it is an important component of nursing practice. Within this position statement it identifies the benefits that clinical supervision will have to the profession, these include;
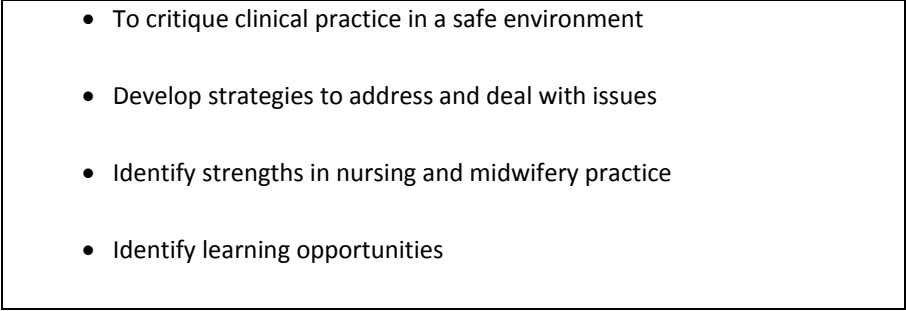
- To critique clinical practice in a safe environment

- Develop strategies to address and deal with issues

- Identify strengths in nursing and midwifery practice

- Identify learning opportunities

Figure 6. Benefits of Clinical Supervision with the NZNO Position Statement

It also identifies key components for clinical supervision to take place. New Zealand Nurses Organisation act as a support for nurses and are committed to providing nurses with support as well as resources that they may require on clinical supervision.

When contact was made with the Nurse entry to practice (NetP) Coordinator's at Auckland, Canterbury and Capital and Coast DHB they had no documentation that supported clinical supervision being available for nurses in general hospital settings. Although some of the NetP Coordinator's made mention that they would look to develop this in the future. At Hutt Valley DHB there was no current documentation, although they had a previous policy which had a review date for 2006. This policy was targeting nurses that worked in independent situations or in areas of high stress. It was good to see that there had been previously a policy that nurses within Hutt Valley DHB could access. The frustrating thing was why did these DHB's not have any current documentation to support the nursing workforce to access clinical supervision if they required it? Could it be that because New Zealand does not have the drive from the Nursing Council to have clinical supervision open to nurses that work in the hospital settings? Other countries such as the United Kingdom and Finland have policy within their nursing councils and ministry to support nurses in attending supervision and then this is developed between the hospitals and health care facilities so nurses are aware of what clinical supervision is and can have access to it when they require it. Or could it be that the previous perceptions and themes that have been dominant in

the literature such as cost, time and resources have made it not an option in New Zealand's current society. The most encouraging point gathered from contacting the DHB's was to know that they are looking to develop it in the future.

Chapter Four: Discussion and Conclusions

This chapter will present a summary of the themes which were the outcome of this modified systematic literature review, which aimed to describe medical and surgical nurse's perceptions and attitudes of clinical supervision. The findings of this study which can also be reflected in the literature will be discussed. The research methodology selected for this study will be discussed including limitations it may have had on the study. Recommendations will be made regarding the place for clinical supervision in the medical/surgical arena.

Confirmed Convictions Regarding the Need for Clinical Supervision

The findings from the articles reviewed shows that nurse's perceived positive outcomes for having clinical supervision implemented for nurses working in general hospital settings (see figure 5. page 46). The literature has shown that nurses working within mental health give the highest evaluation scores for clinical supervision. This is perhaps to be expected given that mental health nurses are generally required to receive clinical supervision as part of their employment contract. This is also be due to most research focussing on implementing clinical supervision into mental health and is yet to be proven in medical and general surgical hospital settings.

Looking at the studies that focussed on nurses working in general hospital settings it found that clinical supervision can also enhance nurse's relationships with their patients in the general setting. It has also been found that the supervisor assists and supports the supervisee to build knowledge, strategies and learn from experiences, therefore improving the relationship between the patient and the nurse as well as building the nurse's wellbeing. The nurse patient relationship is very important as it is this relationship allows the patient to recover, heal and cooperate within the nursing environment which leads to the patient gaining wellbeing (Begat & Severinsson, 2006). Reflection within clinical supervision enables the nurse to

gain a deeper understanding of their own identity. Begat and Severinsson (2006) suggest that if nurses can identify when a patient is troubled or suffering this enables high–quality patient care and clinical supervision can help to develop this. Communication and being involved with the patients care is the best tool in identifying this suffering. Clinical supervision can influence communication and make the health professional more aware of the different words used that can impact a relationship as well having silence, touch or non-touch in a relationship (Begat & Severinsson, 2006). It is important that nurses acknowledge their patients and accept them for who they are. The patient may then feel safe and trust the nurse that is caring for them. A lot of tools can be gained from nurses having clinical supervision that reflect in the relationships nurses have with their patients. Clinical supervision has shown to also benefit nurses by building their trust, confidence, having better coping mechanisms, decreasing anxiety, and improving listening skills. As well as having these positive changes in the nursing role. Nurses can develop their knowledge, this therefore building the role that they work within. Overall it has shown that clinical supervision will develop relationships the supervisee has with patients, colleagues and with other hospitals.

From doing postgraduate study in clinical supervision and having the experience of clinical supervision in my own practice has been very beneficial. It has enhanced the relationships I have had with patients and my colleagues and supported me to build strategies in how to deal with situations in the future. I was not surprised in the literature reviewed that clinical supervision was also beneficial as I have experienced this myself and feel that nurses within general hospital setting should be able to have access to clinical supervision when they require it.

Mixed Messages, Supported Claims, Limited Evidence

The review of the literature did not include all studies on clinical supervision as some of the articles did not meet the criteria for this review. Some of the literature reviewed incorporates material that supports clinical supervision from previous literature reviews which may result in some bias. Also a majority of the studies only had small sample sizes so it is not possible to apply this to a large population. The papers reviewed also incorporated different methods such as using empathy-based stories which has been more ethical than for example the experimental design. This can be criticised as this method can have problems such as brining through non desirable outcomes and even failures. The benefit of empathy-based methods is it encourages the reader to express their opinions rather than ticking boxes. The participants can write about issues they have (Hyrkas et al. 2005). Other papers reviewed in this systematic literature review incorporated questionnaires but at times not all sections of the questionnaires were completed or the questionnaire may have only been completed by nurses who had had supervision therefore giving a positive bias for the study.

Of the District Health Boards contacted in regards to this dissertation none had current policies or guidelines that promoted the general medical or surgical nurses to have clinical supervision. It is also important to recognise that New Zealand Nursing Council and Ministry of Health did not have any documentation to support the implementation of clinical supervision within DHB's. This could be due to not having enough research available to prove the need or the desired benefits for this population. Of the policies and guidelines reviewed the New Zealand Nurses Organisation promoted the use of clinical supervision. If there is to be an implementation it needs to be encouraged from the Ministry of Health and New Zealand Nursing Council as these organisations will impact the DHBs. This would also encourage managers of inpatient settings to offer clinical supervision to nurses and may

help to change the connotations around clinical supervision and the ideas that clinical supervision is used to spy on working colleagues.

As recognised in other countries such as Australia and the United Kingdom it hasn't been until major incident or crisis has occurred that clinical supervision has been implemented. Does this mean for New Zealand there will need to be an incident like this for there to be the opportunity for clinical supervision to be available to nurses working in areas such as medical and surgical? One would seriously hope not.

I have been encouraged by the results of this systematic literature review as it has provided grounding to my own thoughts and I am sure it will provide insights for other health professionals and nurses interested in clinical supervision.

Gains and Limitations of a Modified Systematic Literature Review Approach

Due to clinical supervision having a range of definitions it was important to narrow the search in relation to medical and surgical nurses without sacrificing the quality of this important research. Reading and following the steps of a literature review process enabled the review to stay on target and focus on the topic of the study. The research reviewed for this systematic literature review included both quantitative and qualitative studies which had varying sample sizes and different research methods. The appeal of doing a modified systematic literature review is that it is neutral and provides an objective and transparent process to the reader. It follows a systematic process and identifies research pertinent to the topic. The method of thematic analysis applied to doing a literature review meant interpreting the findings of other studies and grouping the findings. The interpretation of these findings relies on the researcher's judgements and understanding of the phenomena under study. This means that the objectivity of the study is not the same as for a quantitative study. The interpretation may influence the

bias of the findings reported (Sirola-Karvinen & Hyrkas, 2006). This systematic literature review was modified as the qualitative data present in this review had small sample sizes. It enabled me to gather all the research in relation to clinical supervision targeting nurses working in general surgical and medical arena and determine the outcome for this population. It also meant that the researcher could determine where there needed to be further research and if there were any gaps.

This modified literature review highlighted the large benefits that clinical supervision can have for nurses working in the medical and surgical setting's. The benefits of having clinical supervision outweigh the negatives and DHB's should encourage and look to implement or provide supervision to these nurses if it is needed. As the benefits in Figure 5 on page 46 shows that it is supportive, helpful in building trust and confidence within a relationship and develops skills, knowledge, and experience. These benefits have been shown to outweigh the cost and time of clinical supervision which is encouraging if DHB's want to implement this supportive measure.

Unanswered Questions, Extrapolated and Speculative Interpretations

This systematic literature review identified the barriers and perceptions of clinical supervision to nurses working in surgical and medical areas. A large amount of these studies had small sample sizes and identified positive outcomes for nurses working in these areas. It is therefore reasonable to suggest and speculate that clinical supervision is beneficial for this nursing population. It would be of considerable value to see more studies that look at how education in clinical supervision affects this group having clinical supervision. While a lot of research also mentions the cost of supervision, it would be good to see more research looking at the cost in the long term and if by implementing clinical supervision did it help to retain staff with fewer resignations or absenteeism.

Future Research Needed

Due to there being a large amount of research on clinical supervision within the mental health and aged care arenas it would be interesting to see more research looking at clinical supervision being implemented for medical and surgical nurses and whether there needs to be different approaches performed to implement into these two different areas. It would also be interesting to see the differences in the uptake of clinical supervision and to see whether it would still be of benefit. To do this there needs to be a NZ wide research project that surveys and audits a range of nurses that have access to clinical supervision that also includes the cost versus the benefit of the provision of clinical supervision within New Zealand.

It would also be interesting if research was undertaken amongst senior management throughout NZ to establish the impediments and enablers that surround their staff management roles. And to what degree does budgetary constraints actually impede the provision of clinical supervision or is there, for whatever reason, limited conviction that clinical supervision is a worthwhile investment?

Closing Thoughts

This modified systematic literature review process has shown that there is a place for clinical supervision within the realms of the busy surgical, medical nurse. From the earlier days when I was undertaking a postgraduate paper in professional supervision, I have felt deep and unshakable passion for how medical and surgical nurses I work with and others I know all too frequently labour long and hard with minimal or no support of the kind that I know clinical supervision can provide. It troubles me deeply that for all the reasons this dissertation has uncovered, much needed staff support in my area goes unaddressed. I will continue to push for the opportunities for medical and surgical nurses and others to have access to this essential source of support and professional recognition. My colleagues and our patients deserve this. It

is my sincere hope that this small piece of research can contribute positively to the important work nurses do. I have found it extremely frustrating as I see nurses that are faced with difficulties within their practice and often they do not have support to help relieve or improve their current practice. With the socio-economic climate as it is today the working demands for nurses working in these areas it will worsen and nurses will be faced with more pressure. Does it mean that New Zealand nurses working in high demand and technical areas will need to experience a crisis before clinical supervision is implemented?

As I complete this dissertation I am encouraged as there is more research coming to light and of significance as I read the Kai Tiaki Nursing New Zealand Journal there is an article on the West Coast District Health Board implementing a programme to develop their own clinical supervisors for the general nursing workforce (O'Connor, 2012). This is great to see and maybe clinical supervision may be the way forward for the future and help maintain our nursing workforce.

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Appendix

- Table of literature reviewed