



<http://researchspace.auckland.ac.nz>

## ***ResearchSpace@Auckland***

### **Copyright Statement**

The digital copy of this thesis is protected by the Copyright Act 1994 (New Zealand).

This thesis may be consulted by you, provided you comply with the provisions of the Act and the following conditions of use:

- Any use you make of these documents or images must be for research or private study purposes only, and you may not make them available to any other person.
- Authors control the copyright of their thesis. You will recognise the author's right to be identified as the author of this thesis, and due acknowledgement will be made to the author where appropriate.
- You will obtain the author's permission before publishing any material from their thesis.

To request permissions please use the Feedback form on our webpage.

<http://researchspace.auckland.ac.nz/feedback>

### **General copyright and disclaimer**

In addition to the above conditions, authors give their consent for the digital copy of their work to be used subject to the conditions specified on the [Library Thesis Consent Form](#) and [Deposit Licence](#).

### **Note : Masters Theses**

The digital copy of a masters thesis is as submitted for examination and contains no corrections. The print copy, usually available in the University Library, may contain corrections made by hand, which have been requested by the supervisor.

**An exploration of the experiences of mental health and addictions nurses  
providing clinical supervision in a New Zealand District Health Board**

**Emilia Shupikayi Hlatywayo**

**A thesis submitted in partial fulfilment of the requirements for the degree of Master of  
Nursing, The University of Auckland, 2011**

## **ABSTRACT**

Clinical supervision is recognised as valuable due to the stressful nature of mental health nursing. For mental health and addictions nurses, clinical supervision has become an important strategy aimed at providing support and on-going professional development to enable nurses to improve their practice and the quality of client care. In New Zealand, clinical supervisors offer this service but there is little research on their experiences of providing clinical supervision. The present study aims to address this gap and to contribute vital information that will support policy development and management of supervision processes.

The aim of this study was to illuminate the experiences of mental health and addictions nurses who provide clinical supervision in a New Zealand DHB. A qualitative descriptive methodology was used. Data was collected via individual semi-structured interviews from 15 clinical supervisors and was analysed using a thematic analysis.

Analysis of the data revealed four over-arching themes. These are; ‘Acquiring and maintaining the nuts and bolts of clinical supervision,’ ‘Practicing flexibly within supervision frameworks,’ Integrating clinical supervision with nursing practice’ and ‘Working within organisational frameworks’.

The findings show how providing clinical supervision is a rewarding as well as a challenging experience. It requires motivated and well-prepared individuals who are willing to support others’ professional development while reflecting on and developing their own practice. Organisational systems can be either supportive or constraining to the effective implementation of clinical supervision.

The implications of the findings highlight the need for employers and organisations to provide adequate resources, clear policies and procedures that support and enable all mental health nurses to access clinical supervision. Investing in clinical supervision brings out the best in motivated and committed supervisors and in their supervisees.

## **DEDICATION**

This thesis is dedicated to my parents Mr and Mrs Zvamano Bvukumbwe. Their wisdom, guidance and hard work made me who I am.

## **ACKNOWLEDGEMENTS**

First, I would like to thank all the participants who made this research possible by volunteering their time to share their valuable experiences with me.

To my primary academic supervisor Dr Kate Prebble thank you for the guidance, timely feedback, patience and for believing in me when I doubted myself. To my secondary supervisor Tony O'Brien, thank you for the excellent feedback. Many thanks to Kelvin Rossiter, my clinical supervisor for the encouragement and support.

To my husband Morris for being there during the good and not so good times, to remind me when to work, play, eat and knowing when not to say anything at all. Many thanks to my boys Kudzai and Tapiwa for giving me the motivation to learn with you and from you and for the technical support when it got too hard.

I would like to thank my employer and the management of Waikato District Health Board for affording me the time and for providing the resources. Thank you to the Public Service Association and the Nursing and Midwifery Education Fund for funding my study.

To Moira O'Shea for the endless advice and tips throughout the whole journey.

To all my colleagues and friends for listening and encouraging me and allowing me the time and space.

To Lorraine Nielsen at the Philson library and to all the librarians at Waikato Hospital library for their assistance with literature searches and referencing tips.

Finally to Dr Shoba Nayar for assisting with the editing.

## TABLE OF CONTENTS

<b>ABSTRACT .....</b>	<b>i</b>
<b>DEDICATION.....</b>	<b>ii</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>iii</b>
<b>LIST OF TABLES .....</b>	<b>ix</b>
<b>LIST OF ABBREVIATIONS .....</b>	<b>x</b>
<b>CHAPTER ONE: INTRODUCTION .....</b>	<b>1</b>
1.1 Introduction .....	1
1.2 Historical perspectives of clinical supervision .....	1
1.3 Personal statement.....	4
<i>1.3.1 Overseas experience .....</i>	<i>4</i>
<i>1.3.2 New Zealand Experience .....</i>	<i>5</i>
1.4 Aim of the study.....	6
1.5 Justification for the study .....	6
1.6 Structure of the thesis.....	7
1.7 Conclusion.....	8
<b>CHAPTER TWO: BACKGROUND TO CLINICAL SUPERVISION.....</b>	<b>9</b>
2.1 Introduction .....	9
2.2 Current context of clinical supervision in New Zealand.....	9
<i>2.2.1 Background.....</i>	<i>9</i>
<i>2.2.2 The Treaty of Waitangi .....</i>	<i>10</i>
<i>2.2.3 Cultural safety and clinical supervision .....</i>	<i>11</i>
<i>2.2.4 Overview of clinical supervision in New Zealand .....</i>	<i>12</i>
2.3 Defining clinical supervision .....	14
2.4 The purpose of clinical supervision .....	18
2.5 Effectiveness of clinical supervision.....	20
<i>2.5.1 Benefits for clinicians .....</i>	<i>20</i>
<i>2.5.2 Benefits for clients .....</i>	<i>23</i>
2.6 Resources for supporting clinical supervision .....	24
2.7 Theories and models of supervision.....	24
<i>2.7.1 One to one supervision models .....</i>	<i>25</i>
<i>2.7.2 Group supervision models .....</i>	<i>27</i>
<i>2.7.3 Peer supervision .....</i>	<i>28</i>

2.7.4 Tele and video-conferencing .....	28
2.7.5 Cultural supervision .....	29
2.7.6 Multi-professional supervision .....	29
2.8 Conclusion.....	31
<b>CHAPTER THREE: LITERATURE REVIEW .....</b>	<b>32</b>
3.1 Introduction .....	32
3.2 Literature search strategy .....	32
3.3 Literature on clinical supervisors .....	33
3.3.1 Training and support for clinical supervision .....	33
3.3.2 Attributes and characteristics of good supervisors .....	36
3.4 Barriers to clinical supervision.....	39
3.5 Clinical supervision in New Zealand .....	41
3.6 The gap in literature .....	45
3.7 Conclusion.....	46
<b>CHAPTER FOUR: RESEARCH METHODOLOGY .....</b>	<b>47</b>
4.1 Introduction .....	47
4.2 Aims .....	47
4.3 Qualitative research design .....	48
4.4 Qualitative descriptive research .....	49
4.5 Sampling in qualitative research .....	50
4.6 Validity, trustworthiness and rigour in qualitative research .....	51
4.7 Criteria for judging qualitative research.....	52
4.7.1 Credibility.....	52
4.7.2 Transferability .....	52
4.7.3 Dependability.....	52
4.7.4 Confirmability.....	53
4.7.5 Reflexivity .....	53
4.8 Limitations of qualitative descriptive design .....	53
4.9 Research methods.....	54
4.9.1 Study setting.....	54
4.9.2 Study sample .....	54
4.9.3 Recruitment.....	55
4.9.4 Collection of data .....	57

4.9.5 Applying reflexivity.....	59
4.10 Ethical considerations .....	59
4.10.1 Respect for participants.....	60
4.10.2 Informed consent .....	60
4.10.3 Privacy and confidentiality.....	61
4.11 Benefits/risks of taking part in the study.....	61
4.12 Minimization of harm.....	61
4.13 Treaty of Waitangi .....	62
4.14 Ethical approval.....	63
4.15 Data analysis .....	63
4.16 Conclusion.....	65
<b>CHAPTER FIVE: FINDINGS.....</b>	<b>66</b>
5.1 Introduction .....	66
5.2 Acquiring and maintaining the ‘nuts and bolts’ of clinical supervision .....	67
5.2.1 Stepping up to become a supervisor .....	67
5.2.2 Training in the theory and practice of clinical supervision .....	70
5.2.3 Upskilling as a supervisor .....	73
5.2.4 Receiving supervision .....	76
5.3 Practising supervision flexibly within frameworks.....	78
5.3.1 Laying the foundations of the relationship .....	78
5.3.2 Sharing responsibilities .....	81
5.3.3 Focusing on clinical issues in supervision .....	86
5.3.4 Adopting a flexible approach .....	87
5.4 Integrating clinical supervision and nursing practice.....	89
5.4.1 Building on personal and professional attributes and skills .....	90
5.4.2 Developing own nursing practice through providing supervision .....	92
5.4.3 Applying tools of clinical supervision to practice .....	94
5.5 Working within organisational frameworks.....	94
5.5.1 Responding to ambiguous policies .....	94
5.5.2 Working within organisational constraints .....	99
5.5.3 Benefitting from organisational systems .....	104
5.6 Conclusion.....	106
<b>CHAPTER SIX: DISCUSSION AND CONCLUSION.....</b>	<b>107</b>



6.1 Introduction .....	107
6.2 Acquiring and maintaining the ‘nuts and bolts’ of clinical supervision .....	108
6.2.1 <i>Motivation to supervise</i> .....	108
6.2.2 <i>Training for supervisors</i> .....	109
6.2.3 <i>Maintaining competence to supervise</i> .....	110
6.2.4 <i>Own supervision and support</i> .....	111
6.3 Practising flexibly within supervision frameworks.....	111
6.3.1 <i>Laying the foundations of the supervisory relationship</i> .....	112
6.3.2 <i>Sharing responsibilities</i> .....	113
6.4 Focusing on clinical issues.....	116
6.5 Adopting a flexible approach .....	116
6.5.1 <i>Flexible use of models</i> .....	116
6.5.2 <i>Responding to supervisees’ levels of experience</i> .....	117
6.6 Integrating clinical supervision and nursing practice.....	117
6.6.1 <i>Building on personal and professional attributes</i> .....	118
6.6.2 <i>Developing own nursing practice</i> .....	118
6.6.3 <i>Clinical supervision and its link to other clinical and professional skills</i> .....	119
6.7 Working within organisational frameworks.....	120
6.7.1 <i>Mandated clinical supervision</i> .....	120
6.7.2 <i>Negotiating managerial concerns and policies</i> .....	121
6.8 Organisational constraints .....	123
6.9 Benefitting from organisational supports .....	126
6.10 Conclusion.....	127
6.11 Limitations of the study.....	128
6.12 Recommendations .....	129
6.12.1 <i>Research</i> .....	129
6.12.2 <i>Practice</i> .....	130
6.12.3 <i>Policy</i> .....	131
6.13 Summary .....	132
<b>Appendix A</b> .....	133
<b>Appendix B</b> .....	134
<b>Appendix C</b> .....	138
<b>Appendix D</b> .....	140

<b>Appendix E</b> .....	142
<b>Appendix F</b> .....	143
<b>Appendix G</b> .....	145
<b>REFERENCES</b> .....	146

## LIST OF TABLES

<b>Table 1</b> <i>Description of Participants</i> .....	56
<b>Table 2</b> <i>Main themes and subthemes</i> .....	66

## **LIST OF ABBREVIATIONS**

CS	Clinical Supervision
DHB	District Health Board
HPCAA	Health Practitioners Competence Assurance Act (2003)
MOH	Ministry of Health
NCNZ	Nursing Council of New Zealand
NGO	Non-Governmental Organisation
NZNO	New Zealand Nurses Organisation

## **CHAPTER ONE: INTRODUCTION**

### **1.1 Introduction**

This study is concerned with the experiences of mental health and addictions nurse clinical supervisors. The purpose is to explore and describe their experiences of providing clinical supervision. Clinical supervision is a practice used by nurses and other helping professionals to provide support and professional growth for practitioners and to ensure quality client care.

This chapter presents introductory information on clinical supervision. First the historical perspectives of clinical supervision are outlined, followed by a description of my personal experiences of clinical supervision, my motivation to carry out the research, the aim of and justification for the research. Literature that informs the discussion of history of supervision has been included in this chapter. The chapter concludes with an overview of the thesis.

### **1.2 Historical perspectives of clinical supervision**

The origins of clinical supervision are unclear. There are different views and little clarity on its history. Clinical supervision has been described as having its roots in psychotherapy, counselling and the allied health disciplines of social work and psychology (Bernard & Goodyear, 1998) and later on in nursing (Lynch, Happell, & Sharrock, 2008). Given that the concept of clinical supervision has been documented according to specific disciplines with little or no acknowledgements of the work of others, there remains some confusion and uncertainty about its origins (Lynch, Happell, & Sharrock, 2008; Yegdich & Cushing, 1998). However, Emmerton (1999, cited in White & Roche, 2006; White & Winstanley, 2006) states that the concept of supervisor and supervisee relationships have existed since the days of Florence Nightingale when experienced nurses provided guidance to less experienced nurses, including students.

In nursing, clinical supervision was first documented in the United States of America (USA) in the 1930s (Lynch, Happell, & Sharrock, 2008; Yegdich, 1999). Its introduction was in response to changes that were taking place in nursing at the time. These changes included the move from hospital based training, the need to link theory to practice and the expanded roles in nursing. The focus was on developing and sustaining good nursing standards by

ensuring personal growth of the nurses (Yegdich, 1999). For mental health nurses in the USA, clinical supervision became a professional requirement as early as the 1970s (Lynch, Happell, & Sharrock, 2008).

During the first half of the 20<sup>th</sup> century, clinical supervision was used as an instrument of discipline and control (Kelly, Long, & McKenna, 2001). The practice was seen as a means of overseeing nurses' work. Over time, the link between clinical supervision and counselling and psychotherapy made it more attractive to mental health nursing. Burrow (1995) points out that mental health nurses may have long been involved in some forms of supervision. According to Crotty (1998) the continuation and transformation of nursing roles and practice that has occurred support the notion that supervision has always been a part of nursing. However, Kennedy (2007) argues that if the purpose of supervision is to assure best practice, practitioners who claim to have been giving and receiving supervision since they started nursing have no means of knowing whether their care is aligned with best practice or whether other factors may be involved because there is no evidence to support this claim.

In the late 1980s, the need for quality assurance and clinical governance influenced the introduction of clinical supervision in the United Kingdom (Mills, Francis, & Bonner, 2005). Nursing academics and professional bodies in the United Kingdom initiated clinical supervision as an integral part of nursing practice (Davey, Desousa, Robinson, & Murrells, 2006). The latter half of the century also saw increased concern of the effects of strain related to mental health work and the emergence of clinical supervision as an activity for reflection and education (Buus & Gonge, 2009). Clinical supervision was considered important to establish and maintain effective mental health workforce (Cleary, Horsfall, & Happell, 2010) by providing practitioners with lifelong learning, reflective practice, practice clarification, feedback and validation (Clouder & Sellars, 2004; Jones, 2003).

Australia and New Zealand have been slow to take up clinical supervision for nurses. Until very recently clinical supervision has been largely ignored in nursing. It is speculated that the reason for the slow uptake of clinical supervision is that it was recommended exclusively for mental health nurses (Cummins, 2009; Winstanley & White, 2003). In New Zealand the commonly used models of clinical supervision were the TAPES model (O'Donoghue, 1998) and the Role theory model (Consedine, 2001). The TAPES model focused on brainstorming and identification of strategies for working with clients. According

to Herkt and Hockin (2007) the model was open to all disciplines and it became the foundation on which much of the clinical supervision in New Zealand was based. The TAPES training for mental health practitioners course was run by an educational institution, WelTech and required practitioners to attend for periods of up to five days at a time.

The acronym TAPES represents five categories into which supervision issues are placed and addressed: theory; assessment and intervention planning; parallel processes; ethical and professional practices; and strategies and intervention techniques. The model allows supervisors to use a series of questions to prompt the supervisee to reflect. ‘Theory’ refers to when the supervisor asks or informs the supervisee about theories and policies that inform or influence particular decisions. ‘Assessment and intervention planning’ is in relation to identified issues brought to supervision. ‘Parallel processes’ refer to unconscious mirroring of situations and feelings within the supervisory process involving the supervisor, supervisee and the client. The concept of parallel processes was first described by Searles (1955, as cited in Morrissey & Tribe, 2001) as a reflective process involving the appearance of dynamics in the supervisee and client interaction that are mirrored in the dynamics between the supervisor and supervisee. Ekstein and Wallerstein (1972, as cited in Morrissey & Tribe, 2001) further described parallel process in terms of its ability to facilitate learning for client work as well as for the development of the supervisor and supervisee. ‘Ethical and professional practices’ relate to practising in a safe manner within appropriate standards. In clinical supervision ethical competence depends on the supervisory relationship to support development of the supervisee’s professional identity, autonomy and responsibility for the client. The supervisee is assisted to reflect on core human concerns and to integrate nursing theory (Berggren, Barbosa da Silva, & Severinsson, 2005). Finally, ‘Strategies’ refer to the identification of strategies and the application of appropriate interventions for given situations. Due to high costs the TAPES model was abandoned in favour of more eclectic models offered by various tertiary institutions throughout New Zealand Herkt (2005 cited in Mckenna et al, 2008).

Consedine (1995, cited in Robertson, 2000) developed a clinical supervision training programme for nurses that was based on the notion role development. The Role theory model was used in training workshops for mental health nurses both in New Zealand and Australia (Consedine, 2001). The model used psychodrama to expand supervisees’ experience of the links between the systemic nature of life and relationships. In this model supervisors use strategies of “concretisation, role analysis, mirroring and modelling” and they built on

supervisees' pre-existing " personality and functioning" to develop supervisees' sense of professional identity as they become more conscious of their behaviour and its effects on clients and others (Consedine, 2001, p. 48). According to Mernick (2009) the model involved 20 training days over two years followed by yearly two day refresher courses and was well received in the mental health service.

### **1.3 Personal statement**

I have worked as a general and mental health nurse for over two decades with exposure to different settings locally and internationally. During the course of my work I developed an interest in the area of clinical supervision for practitioners whose work involves intense emotional interactions. Mental health nurses fall into this group of practitioners.

#### ***1.3.1 Overseas experience***

I am a mental health nurse whose previous work in several countries exposed me to mainstream mental health nursing, and working with refugees, victims of child physical and sexual abuse, domestic violence, sexual assaults, organised violence and torture. The work involved day to day bio-psycho-social needs assessments, provision of medical and psychiatric care, trauma counselling, death investigations, rehabilitation, extensive documentation of human rights abuses and compiling reports for the courts. Because of my experience I provided what was then called 'clinical supervision' to other nurses at a national and regional level.

Practitioners who worked in the above settings often experienced burnout and vicarious trauma that impacted on their personal and professional well-being. One way to deal with these personal and professional issues was to engage in one-to-one and peer discussions about the work. The aim of these discussions was to ensure that nurses received support around their decision making and clinical skills. In addition to debriefing, the aim of this clinical supervision was to ensure that clinical skills were maintained and developed and that practitioners were knowledgeable, confident and accountable for their actions especially in the face of scarce human, financial and material resources. I travelled round the country to supervise and support the nurses in the field and held discussions around clinical progress. I had no formal training for the supervisory role so I used my own interview and clinical skills and experience. In retrospect, the supervision role overlapped a lot with mentorship and



preceptorship roles because I would often perform any of these roles depending on the needs of the practitioners. I wondered whether clinical supervision was sometimes confused with the concept of 'supervised clinical practice' provided to nurses in training. There were no guidelines for the provision of clinical supervision. Individual organisations and hospitals devised their own methods of ensuring that some form of supervision and support took place. Heads of the hospitals and clinics that I visited did not have the capacity to provide supervision for the nurses involved in this work. Therefore, the task was left to the Non-Governmental Organisation [NGO] trainers, such as me to ensure that nurses attained skills and competencies required for their jobs.

I received my own supervision from my line manager. I met with him at the beginning of every week to give feedback on the previous week's work and to plan for the work ahead. In addition I submitted monthly reports to the Clinical Director. Sometimes I met with my manager ad hoc, for example, to discuss change of plans or to check-in if I felt stuck on an aspect of the project. On reflection, I was not aware of any theories underpinning either the supervision that I received or the supervision that I provided. There were no processes or structures for the implementation or evaluation of the supervision. Some of our discussions touched on techniques about self care but made no reference to how the techniques linked to supervision and practice.

### ***1.3.2 New Zealand Experience***

When I came to New Zealand to work as a mental health nurse in a District Health Board [DHB], my team leader informed me that clinical supervision was in place and that health professionals were encouraged by the DHB to take it up. Information about supervisors and supervision was scanty and unclear so that I did not take up any supervision for over a year. At the time some mental health nurses within the service received a two week training course in clinical supervision after which they provided clinical supervision to other nurses. They used the TAPES model (O'Donoghue, 1998). At the same time, the New Zealand government enacted legislation (Health Practitioners Competence Act 2003) [HPCAA] aimed at protecting the public and to ensure competence and accountability in health care.

In 2006, the DHB in conjunction with the local Institute of Technology established a new type of clinical supervision training for health professionals. This was a one year part-time certificate course that covered theories and models as well as organizational, ethical and

legal responsibilities in clinical supervision. My interests in learning about the theory and practice of clinical supervision led me to enrol in the course. Since the course I have been providing clinical supervision to fellow nurses in the DHB. I commonly use Proctor's (2001) Three Function Interactive model to apply it to the particular issues that are brought to supervision. The formative, normative and restorative functions of the model integrate well with the different aspects of mental health nursing practice. I also draw on other models that apply the principles of adult learning and facilitate reflection as with the Experiential Learning Cycle of Reflection (Kolb, 1984). A detailed description of supervision models is provided in more detail in chapter two.

#### **1.4 Aim of the study**

The aim of this study is to explore and describe the experiences of clinical supervision from the perspectives of those who provide it. In this study respondents were nurses working in the mental health and addictions service and who provide clinical supervision. It was anticipated that findings from the study would shed more light on clinical supervision in the nursing profession and inform DHBs about how clinical supervision should be implemented.

#### **1.5 Justification for the study**

Past and present personal and professional experiences influenced my interest and participation in the training and provision of clinical supervision. My experience of being a supervisor has had elements of fulfilment, satisfaction, apprehension and confusion. However in contrast to my experience of supervision elsewhere, I have found that clinical supervision in New Zealand is more formal in that the organization supports and endorses it and that supervisors receive training for the role.

As a supervisor I share stories with supervisor colleagues who have local and overseas clinical supervision training and experiences. We discuss various experiences and practices and it was during these discussions that questions arose: What do clinical supervisors do? How do clinical supervisors meet the objectives of clinical supervision? What drives them to perform clinical supervision? How do their values, beliefs and backgrounds affect supervisory relationships? What issues and concerns arise for them during supervision? How are they addressed? There are personal and organisational expectations and

requirements for this role that needed further clarification. Anecdotal information indicated that clinical supervisors perform complex tasks and that their role is supported and/or constrained by personal and organisational factors. Although there is some literature on clinical supervision from other nursing disciplines and from the allied disciplines of social work, counselling and psychotherapy, research that focuses on mental health nurse clinical supervisors' experiences of their role is limited. If New Zealand nurses are to be fully supported to provide clinical supervision in DHBs and other mental health and addictions services, it is important that the supervisor experience be understood. This is particularly vital within DHBs which employ most mental health and addictions nurses, and provide the most acute and complex care. Currently there is a gap between policy and practice in relation to provision of clinical supervision for nurses in New Zealand. This gap is explored in the next chapter.

## **1.6 Structure of the thesis**

Chapter one has provided an introduction to the thesis. The historical perspectives of clinical supervision have been described including the researcher's experiences of clinical supervision, motivation and justification for the study.

Chapter two provides a background and an overview of clinical supervision in New Zealand. The significance of the Treaty of Waitangi and cultural safety are described. Some general definitions of clinical supervision and an operational definition of clinical supervision have been provided to place the study into context. The purpose and effects of clinical supervision and supervision models are described. Literature that supports discussion of these topics has been included in this chapter.

Chapter three reviews the literature relating to clinical supervisors in New Zealand and internationally. The gaps in the literature are identified.

Chapter four describes the qualitative descriptive research as the methodology chosen for the research. Ethical issues and steps taken to ensure rigor are outlined. Data collection and data analysis methods used are explained.

Chapter five presents the findings of the study. Quotes from the interviews are presented to support the findings.

Chapter six discusses the study findings in relation to current literature on clinical supervision. Limitations of the study are discussed. The implications of the findings and recommendations for future research, practice and policy are also considered. Finally a brief conclusion to the thesis is provided.

## **1.7 Conclusion**

Although there is a general recognition for the need for clinical supervision and its benefits for supervisees, clients and organisations, there is little evidence to inform this argument from the perspectives of supervisors. Experiences and perspectives of clinical supervisors require further exploration to elucidate the impact of their contribution to the process of clinical supervision. It is anticipated that the knowledge obtained from this study will add to the existing body of knowledge on clinical supervision and assist DHBs and other mental health and addiction services to develop supervision processes that best meet the needs of the nursing workforce and the recipients of mental health care. An exploration of supervisor experiences will inform mental health nursing practice and assist nurse leaders, managers and policy-makers to develop and sustain system to support effective clinical supervision. The findings will also contribute to the current body of international and local literature.

This chapter has provided an introduction to the thesis and the purpose for conducting this research. The historical development of clinical supervision has been described and the researcher's personal statement and motivation for undertaking the research have been explained. The next chapter describes clinical supervision in New Zealand. Definitions; purpose; effectiveness and some models of clinical supervision are described.

## **CHAPTER TWO: BACKGROUND TO CLINICAL SUPERVISION**

### **2.1 Introduction**

Chapter one has presented the historical perspectives of clinical supervision. It outlined a description of my personal experiences of clinical supervision, my motivation to carry out the research, the aim of and justification for the research. The chapter concluded with an overview of the thesis.

This chapter describes the current context of clinical supervision in New Zealand and the significance of the study. The significance of the Treaty of Waitangi and cultural safety in clinical supervision is described. This is followed by a description of the key concepts of clinical supervision; definitions including the operational definition of clinical supervision used in this study, the purpose of clinical supervision and its benefits. The final section describes some of the theories and models of clinical supervision used in mental health nursing.

### **2.2 Current context of clinical supervision in New Zealand**

#### ***2.2.1 Background***

In New Zealand, clinical supervision is recommended as one method of ensuring public safety, ongoing professional development and safe practice (Ministry of Health, 2000). Clinical supervision is seen as a quality improvement strategy which improves outcomes for service users and reduces stress for staff. Additionally practitioners are required to demonstrate that they are competent to practice.

There have been efforts to encourage the use of clinical supervision by various stakeholders. The government, nursing organisations and regulatory bodies support the need for clinical supervision for nurses. The Health Practitioners Competence Assurance Act (2003) (HPCAA) requires practitioners to protect the health and safety of the public by providing for mechanisms to ensure that nurses are competent and fit to practice and are able to obtain annual practising certificates. In response to the HPCAA requirements, the Nursing Council of New Zealand [NCNZ] as the regulatory authority for nurses recommends that nurses engage in clinical supervision as one way of maintaining competence and fitness to

practice (Nursing Council of New Zealand, 2007). Clinical supervision, it is argued, helps to develop practitioner's skills. New Zealand Nurses Organization [NZNO] (2005), in their position statement on clinical supervision state that "Professional and clinical supervision is recognised as a critical component of nursing and midwifery practice. The NZNO believes that professional and clinical supervision should be available for all nurses and midwives and supports initiatives to achieve this" (p.1). Clinical supervision is also recommended in the *Standards of Practice for Mental Health Nursing in New Zealand* (Te Ao Maramatanga: New Zealand College of Mental Health Nursing, 2004). This document informs and provides guidance around the knowledge, skills and attitudes required for competence, professional development and public accountability of mental health nurses. Standard Five makes reference to the need for mental health nurses to maintain and enhance their own competency and to support the professional development of colleagues. It recommends that nurses reflect on their practice by engaging in peer reviews and supervision. The Ministry of Health (2006) in its discussion framework document *Mental Health Nursing and its Future* acknowledges the implementation of clinical supervision as a professional development as well a staff retention strategy. The report concludes that there is variability and inconsistency in the ways clinical supervision is provided in District Health Boards (DHB) and Non-Governmental Organisations (NGO). It also recommends appropriate training of supervisors to meet the needs of colleagues requiring clinical supervision. By examining the experience of providing supervision, this thesis aims to contribute to an understanding of personal, organisational and policy factors that support or constrain this role. In doing so, it will help to bridge the gap between aspirations of policy-makers and professional bodies and the experience of many nurses who currently miss out on the benefits of regular clinical supervision.

### ***2.2.2 The Treaty of Waitangi***

The Treaty's principles of partnership, protection and participation are significant in improving the health status of Maori. The principles also need to be addressed in the implementation of clinical supervision. The Treaty of Waitangi is the founding document for relationships between Maori and the Crown in Aotearoa/ New Zealand (Ministry of Health, 2002a). The Treaty was signed in 1840 to address the effects of colonisation. Colonisation resulted in the alienation of Maori land, the imposition of systems based on English law and practices that undermined Maori law, religion, education, health language and culture. The

Crown sought to enable peaceful negotiations for settlement of Maori with immigrants and the Treaty recognised the prior occupation by Maori in New Zealand.

Within health services, the Treaty gives priority to Maori health, involvement of Maori, and funding of Maori health initiatives with the aim of improving Maori health status (Papps & Ramsden, 1996). According to Wiley (2009) Maori comprise a significant proportion of users of health services with the health status of Maori being recognised as a priority (Ministry of Health, 2002a). The Treaty requires government departments and statutory bodies to acknowledge and act in a manner consistent with the Treaty and to consult and collaborate with Maori to determine their needs and attitudes (Mental Health Commission, 1998). Thus it is an expectation of the Government that the Ministry of Health and DHBs work towards reducing inequalities in health outcomes. The principles of the Treaty of Waitangi form part of the basis of interactions between nurses and Maori service users during the provision of healthcare. The Treaty's principles of partnership, protection and participation and self determination require nurses to be responsive the needs of Maori and to provide effective interventions (Nursing Council of New Zealand, 2005). Improving mental health status of people with severe mental illness and minimising harm caused by the use of alcohol and illicit substances can be achieved by improving responsiveness of services to Maori.

According to the *National Guidelines for Professional Supervision of Mental Health and Addictions Nurses*, both the professional supervision relationship, and the relationship between the service users and supervisees should reflect the Treaty's principles (Te Pou, 2009). New Zealand's commitment to the Treaty of Waitangi calls for a skilled Maori mental health and addictions workforce that needs to be "supported, nurtured and encouraged to continue to develop Maori models of supervision practice as well as their clinical and cultural skills (McKenna, Thom, Howard, & Williams, 2008 , p. 41).

### ***2.2.3 Cultural safety and clinical supervision***

As a way of ensuring that the principles of the Treaty are incorporated into Maori mental health services, the role of clinical and cultural supervision in consultation with and participation of Maori is acknowledged. Cultural safety is reflected as one of the Nursing Council of New Zealand (NCNZ) standards required by nurses to ensure that they are competent to care for the public of New Zealand. Originally written by Ramsden (1992)

guidelines for cultural safety were later developed by the NCNZ who defined cultural safety as:

The effective nursing practice of a person or family from another culture and is determined by that family of person. Culture includes but is not restricted to age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnicity or migrant status, religious or spiritual beliefs and disability. (Nursing Council of New Zealand, 2009, p. 4)

Papps and Ramsden (1996) expand this definition adding that nurses should be able to reflect on their own cultural identity and recognise the impact of their own culture on professional practice so as to become culturally competent. Competence in cultural safety influences the outcomes of clinical supervision as the nurse focuses on integrating culture into the clinical interaction (McKinney, 2006). One strategy recommended to achieve this is the provision of mainstream and Kaupapa Maori Services which incorporate cultural and Kaupapa Maori supervision (Eruera, 2005; McKinney, 2006; Ministry of Health, 2002b). This study while not focussing on kaupapa Maori supervision includes opportunities for participants to reflect on their experience of providing supervision that supports culturally safe practice.

#### ***2.2.4 Overview of clinical supervision in New Zealand***

While clinical supervision has been an integral part of mental health nursing practice in New Zealand for more than 10 years, there have been few studies conducted on the subject in this country. Most New Zealand literature on clinical supervision comes from allied health professions of social work, occupational therapy, counselling and psychology with some emerging interests to implement clinical supervision in general nursing and midwifery.

Literature on social work supervision in New Zealand indicates that clinical supervision has been carried out for more than four decades. It is a process that takes place between a social work supervisor and supervisees to facilitate reflection within social work practice (O'Donoghue, 2000). In occupational therapy practice Herkt and Hocking (2007) reported that clinical supervision is endorsed and regulated. Occupational therapists are required to receive clinical supervision, identify and participate in professional development activities as part of requirements to maintain competence for recertification (Occupational Therapy Board of New Zealand, 2004a).



Walker (2009) advocated for clinical supervision to be introduced for senior nurses who work in specialist roles such as clinical nurse specialists, nurse practitioners and nurse educators. Walker pointed out that advanced practitioners who work autonomously are prone to stress, isolation and conflict. Clinical supervision can reduce isolation and enhance communication and networking and can help nurses to manage professional and organisational conflict (Brunero & Stein-Parbury, 2008).

New Zealand midwives who are new to practice, new to the country and wish to obtain ongoing support and professional development are seeking and receiving clinical supervision (Lennox, Skinner, & Foureur, 2008). Anecdotal evidence indicates that an increasing number of self employed midwives are accessing clinical supervision in New Zealand. However the unregulated and unlegislated nature of clinical supervision within midwifery means that access to it is by individual choices and its effects are difficult to monitor.

Much of the work around improving mental health services in New Zealand in the past decade has been drawn together into the *Let's Get Real Framework* (Ministry of Health, 2008). The framework consists of seven Real Skills that are shared by all those working in mental health and addictions service. These skills are: 1) working with service users; 2) working with Maori; 3) working with families/whanau; 4) working within communities; 5) challenging stigma and discrimination; 6) law, policy and practice; and 7) professional and personal development. The framework is intended to complement professional competencies and the requirements of the Health Practitioners Competence Assurance Act (HPCAA) (2003) in developing essential knowledge, skills and attitudes required to deliver quality services. Enhancement of performance and professional development through clinical supervision is part of this framework.

A review to investigate current approaches to clinical supervision internationally and for mental health and addiction nurses in New Zealand DHBs and NGOs revealed the need for staff and management commitment to clinical supervision (McKenna et al., 2008). The review provided the following recommendations: development of national supervision guidelines; development of a national training structure for supervision which aligns with *Let's Get Real Framework*; training that focuses on the structure of supervision rather than being model specific; development of accreditation processes; development of a national

database of trained supervisors, and research based evaluations of clinical supervision. As a follow through to the recommendations, a set of national guidelines for implementing and sustaining clinical supervision in New Zealand were developed (Te Pou, 2009). The guidelines discuss the context, description and definition in which clinical supervision takes place, outlines the steps to be taken in conducting clinical supervision, the roles, responsibilities and relationships of all parties concerned and details of how to implement clinical supervision within organisations. In response to the recommendations of the review of clinical supervision for mental health and addictions nurses undertaken by McKenna et al., (2008) and the national guidelines developed by Te Pou (2009), a pilot study was undertaken to develop training that aligned with the *Let's Get Real Framework* (Ministry of Health, 2008). The study implemented and evaluated a supervision training programme in one DHB for supervisors and supervisees and was aimed at making recommendations for implementing and maintaining clinical supervision in other New Zealand DHBs (Te Pou, 2010). The study findings indicate that management support is essential in the implementation of clinical supervision. It recommended that DHBs take planned approaches that include standardized training and supervision practices for managers, supervisors and supervisees.

### **2.3 Defining clinical supervision**

There are many definitions of clinical supervision. The definitions are context related and differ according to the various functions supervision is thought to fulfil. For example, the term supervision was first derived from industry where supervision was viewed as a hierarchical approach in which a supervisor used their authority to demand that work be done (Kilcullen, 2007).

In clinical practice the term supervision is often confusing and difficult to define (Farrington, 1995a). According to Bond and Holland (1998b) there are no widely accepted definitions of clinical supervision. Buus and Gonge (2009) point out that defining and redefining of clinical supervision to fulfil different professional and educational aims adds further confusion. The context driven meanings highlight the importance of clarification of definition and goals of clinical supervision. Practitioners are cautioned against accepting a “taken for granted” meaning of clinical supervision (Jubb Shanley & Stevenson, 2006, p. 592).

The term clinical supervision is often used interchangeably with professional supervision. Clinical supervision refers to supervision that focuses on clinical practice whereas professional supervision describes supervision that takes into account academic, management and leadership practices (Te Pou, 2011). Herkt (2005) however, suggests that supervision provided by a supervisor within one's discipline is referred to as clinical supervision whereas supervision offered from another discipline is called professional supervision. Furthermore Wepa (2007) uses the terms clinical and professional supervision interchangeably and draws on the experiences of social work, mental health nursing, counselling, Plunket nursing and allied health professions.

In nursing, clinical supervision has had many definitions (Winstanley & White, 2003). Thus concepts of clinical supervision with managerial supervision often overlap resulting in much confusion and suspicion around what supervision is (Walsh et al., 2003). Lyth (2000) reiterated that the varied nature of nursing practices challenges the concept of clinical supervision and that trying to fit in a tight definition should be avoided. Using a concept analysis, Lyth proposed a definition of clinical supervision that attempted to bring about more understanding and insight by those involved in supervision. Clinical supervision was defined as:

Clinical supervision is a support mechanism for practising professionals within which they can share clinical, organisational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills. This process will lead to an increased awareness of other concepts including accountability and reflective practice. (Lyth 2000, p. 728)

Rice et al. (2007) expanded on this definition and formulated a comprehensive definition developed from a number of previously published definitions relating to mental health nursing. Clinical supervision was defined but not limited to; a process of protected time for professional support and learning that is supervisee-led; a process that enables practitioners' development of knowledge, competence and skills to provide quality care; an ongoing process that bring supervisors and supervisees together in supportive environments; advancing clinical autonomy and self-esteem and leads to personal and professional growth; a process that facilitates reflection.

Other authors and disciplines have developed their own definitions of clinical supervision. According to Halpern and McKimm (2009) “supervision can be read as overseeing, looking over someone’s shoulder to check on them and also super in the sense of outstanding or special: helping someone to extend their professional skills and understanding”(p. 226). However, the notion of clinical supervision as a form of surveillance highlights the perception that supervision practice can create mistrust and resistance (Clouder & Sellars, 2004). Clouder and Sellars (2004) argue that reflective practice in clinical supervision has the effect of making surveillance explicit, thereby dispelling such tensions.

In the USA the term clinical supervision is used to describe the education and guidance that is provided to students in training or to new graduates. According to Cutcliffe and Lowe (2005) guidance is given by practitioners who are not formally trained in clinical supervision. The term does not relate to other supervisory relationships or to partnerships and it implies the evaluation of performance that has an inherent imbalance of power (Rounds, 2001). For this reason, this type of supervision does not have direct relevance to this study.

In the United Kingdom and the Scandinavian countries the term clinical supervision refers to professional development and support that is given to practitioners via a formal exchange of information and partnership (Teasdale, Brokkehurst, & Thom, 2001). The exchange between practitioners focuses on case reviews, caseload issues and treatment interventions (Gilmore, 1999). In contrast to the American conceptualization, Gilmore (1999) described clinical supervision as a supervisee-led practice with no power differentials.

The term clinical supervision is often used interchangeably with mentoring and preceptoring (Farrington, 1995a; Mills et al., 2005) adding more confusion to what clinical supervision is. To place clinical supervision in perspective, the differences and similarities between mentorship and preceptorship need to be highlighted. The concept of mentoring is based on the notion of a teaching and learning relationship that involves development and change over time (Mills et al., 2005). The emphasis is on expansion of knowledge and career progression. Preceptoring on the other hand is committed to skills acquisition within specified time frames (Usher, Nolan, Reser, Owens, & Tollefson, 1999).

Supervision in medicine pertains to two distinct activities of education and clinical focus (Halpern & McKimm, 2009). The educational aspect is defined as the provision of guidance and feedback to students to assist them to acquire skills and knowledge that enable

them to provide safe and appropriate care. The clinical aspect relates to conversations and feedback on real everyday practice issues and situations (Department of Health, 2007, as cited in Halpern & McKimm, 2009). While there appears to be some overlap between educational and clinical supervision, Halpern and McKimm (2009) asserted that clinical supervision addresses a wider range of patient focused dilemmas.

Definitions of clinical supervision have been established in many other disciplines including social work, education, counselling and psychology. One example, from social and educational settings highlights the similarities with the definitions mentioned above and defines supervision as:

a specific learning, developmental and supportive method of professional reflection and counselling, enabling professional workers (school counsellors, teachers, childcare workers, psychologists, social workers etc) to acquire new professional and personal insights through their own experiences. It helps them to integrate practical experiences with theoretical knowledge and to reach their own solutions to the problems they meet at work, to face stress efficiently and to build up their professional identity. By this, supervision supports professional as well as personal learning and development of professional workers. (Zorga, 2002, p. 265)

There is no single definition that encompasses all elements of clinical supervision. The essence of clinical supervision is around support, quality assurance and the professional development of practitioners who partake in it. For the purposes of this study and to place clinical supervision within the New Zealand context, the operational definition of clinical supervision is “a formal process that provides professional support to enable practitioners to develop their knowledge and competence, be responsible for their own practice, and promote service users’ health outcomes and safety” (Ministry of Health, 2006 , p. 22). The study also takes into account the clarifying adage suggested in the research by McKenna et al, (2008) that clinical supervision “involves time away from the practice environment to meet with an experienced practitioner of their choice to engage in guided reflection on current ways of practice” (p. 2).

## **2.4 The purpose of clinical supervision**

Good nursing practice is dependent on the ability of nurses to apply knowledge to their decision-making and interventions. Assimilation of theory into practice can be achieved when nurses support each other and reflect on their work through clinical supervision (Kennedy, 2007). Butterworth, Bell, Jackson, & Pajnkihar (2008) pointed out that the complexity of mental health nursing and professional isolation for community mental health nurses required nurses to develop professionally by participating in clinical supervision.

The nature of mental health nursing requires a skilled and healthy workforce who are able to deliver quality services and one method to develop and sustain this workforce is through providing clinical supervision (Kelly et al., 2001). Studies have shown that the skill level and practice of clinical supervisors plays a pivotal role in the implementation of supervision in nursing. However, the role of supervisor is multifaceted and often unclear (Farrington, 1995a) .

Literature on clinical supervision suggests an increased interest in its uptake in nursing due to the continued development of nursing roles and the challenging environments that nurses work in. According to Butterworth (1994) practitioners require support to meet such challenges and to sustain and enhance their development. Butterworth and Faugier (1992) suggested clinical supervision as one way of providing such support. The purpose of clinical supervision is to improve nursing practice through guided reflection within the practice-based disciplines and to provide opportunities for nurses to actively support one another (Brunero & Stein-Parbury, 2008).

Rice et al. (2007) highlight the need for clinical supervision because of the complexity of mental health nursing particularly with the move to community based treatment, the emphasis on risk management, the need to conform with regulatory requirements for registration, and organizational calls for quality of care. The shift of nursing from task-oriented to individualised care place nurses at risk of developing unclear personal and professional boundaries. Thus clinical supervision helps nurses to examine these parallel processes (Playle & Mullarkey, 1998).

Mental health nurses have been reported as one professional group that experiences the highest levels of occupational related stress (Edwards & Burnard, 2003). Work related stress can lead to burnout, staff turnover, absenteeism, poor morale and reduced efficiency

and performance (Sutherland & Cooper, 1990, as cited in Edwards & Burnard, 2003). A review of literature on stress management interventions for mental health nurses reported that most stress was a result of “organisational and administrative problems, client related issues, heavy workloads, interprofessional conflict, financial and resource issues, professional self doubt, staffing levels, changes in the health service, maintenance of standards and poor supervision” (Edwards & Burnard, 2003, p.195).

A systematic review of literature on the prevalence of stress in nurses working in adult in-patient wards did not explicitly support the assumption that in-patient nurses expressed high levels of stress and burnout (Richards et al., 2006). This may be due to the small number of studies used in the review and methodological flaws. However the findings suggest that stress levels are influenced by peripheral factors such as management and leadership style rather than the acuity of the client population.

Psycho-social factors play a part in increasing stress on both mental health practitioners and their clients. MacCulloch and Shattell (2009) asserted that stressful political, socio-economic climates place greater need for support of mental health practitioners through clinical supervision. Inadequate resources coupled with high client acuity and community expectations expose practitioners at risk of burnout. Clinical supervision has a role in providing hope for clients through resourcing of their practitioners. MacCulloch and Shattell suggest that clinical supervision provides a medium that allows “practitioners to be nourished affirmed, challenged and refreshed” (p.590).

New employees and recently qualified practitioners, in particular require support. Clinical supervision for new nurse graduates provides supportive relationships necessary for the socialization and incorporation of the nurses into health care practice (Cummins, 2009). According to Mills, Francis and Bonner (2005) the quality of the transition from student to graduate through clinical supervision is key to ensuring staff retention. Hines-Martin and Robinson (2006) recommend the provision of clinical supervision within learning environments to enhance knowledge, competence and autonomy and to enable practitioners to manage clinical issues effectively.

## **2.5 Effectiveness of clinical supervision**

The need to evaluate the effects of clinical supervision on supervisors, supervisees, clients and the organisations is reflected in a range of literature. Butterworth, Faugier and Burnard (2001) suggest that judgements on the impact of clinical supervision should show the link between clinical supervision, work practices and the well-being of the workforce. Due to the lack of full implementation of clinical supervision, however, it is not easy to evaluate its effects on clients and families. Studies on the effectiveness of supervision on clinicians and clients are summarised below.

### ***2.5.1 Benefits for clinicians***

The nature and demands of nursing as with other caring professions contributes to stress and burnout (Dickinson & Wright, 2008). According to Coffey and Coleman (2001, as cited in Edwards et al., 2006), clinical supervision has been found to assist staff to cope within stressful environments. It is regarded as a positive activity that is valued by many nurses. In an evaluative survey study Teasdale, Brocklehurst and Thom (2001) used a blend of qualitative and quantitative methods to determine the effect of clinical supervision on 211 nurses. The study involved one group of nurses who had been receiving formal clinical supervision and another group who received informal support. The qualitative analysis revealed that the nurses benefitted from both formal and informal supports of supervision. The analysis further revealed that the nurses used formal supervision for reflection and called on informal supports for immediate support. The quantitative analysis, however, indicated that clinical supervision had no effect on the burnout levels among the nurses.

Clinical supervision as a means of problem solving increases the understanding of professional issues and enhances practice (United Kingdom Council for Nursing, Midwifery and Health Visiting, 1996, as cited in Walsh et al., 2003). Through problem solving, risk management practices are identified and implemented thereby supporting safe practice (Kennedy, 2007).

An evaluation of a clinical supervision project known as the Clinical Supervision Evaluation Project [CSEP] done in the United Kingdom received positive response from the nurses who felt that clinical supervision allowed them to talk meaningfully to trusted colleagues about their work. Nurses who received clinical supervision suffered less psychological distress than those who did not (White et al., 1998).



In a Finnish survey of 700 general nurses, mental health nurses and specialist nurses, Hyrkas, Appelqvist-Schmidlechner, and Haataja (2006) used validated tools; the Manchester Clinical Supervision Scale [MCSS] and the Maslach Burnout Inventory [MBI] to evaluate the effectiveness of clinical supervision on job satisfaction, quality of client care and burnout. The MCSS measures the quality and effectiveness of clinical supervision and the perception of the effectiveness of supervision on professional development, improvement of skills, reflection, and the quality of supervisory relationships (Winstanley, 2000). The MBI measures emotional exhaustion, depersonalization and personal accomplishment (Maslach & Jackson, 1986). High mean scores for emotional exhaustion and depersonalization reflect high levels of burnout while for personal accomplishment high mean scores indicate low burnout. Low levels of burnout, job satisfaction and the quality of care provided indicated that clinical supervision is effective. An earlier study of 512 mental health nurses using the MCSS found that a positive evaluation of clinical supervision was linked with lower levels of depersonalisation. Positive evaluation was also related to personal accomplishments while the less positive evaluation related to increased job satisfaction (Hyrkas, 2005).

According to a Welsh study of 260 community nurses conducted by Edwards et al. (2006) lower levels of burnout were related to high evaluations of clinical supervision on the MCSS. Earlier studies on clinical supervision and burnout had produced contradictory results due to methodological weaknesses, LoBiondo-Woods & Haber (2006) and the lack of a validated tools to measure the effectiveness of supervision (Winstanley, 2000).

Stress and burnout have also been reported to be high in nurses caring for forensic mental health clients (Mason, 2002). Evidence of stress and burnout has been highlighted in a literature review by Dickinson and Wright (2008). The review identified that access to support systems such as critical incident analysis, stress management training and staff rotation as well as training staff in psychosocial interventions helped in reducing stress. The studies that were reviewed did not specify clinical supervision as an activity that reduces stress. The authors recommended the need for support structures that promote continued professional development and access to regular clinical supervision.

Barriball, While, and Munch (2004) found that clinical supervision was perceived to benefit practice as well as individual practitioners. Clinical supervision has the potential to standardize practice and promote learning and development. Organisational support including

training more supervisors, maintaining records of available supervisors and prioritising clinical supervision can maximise the benefits. For individual practitioners clinical supervision afforded opportunities to reflect and grow in the profession.

Bedward and Daniels (2005) found in their evaluation of the outcomes of clinical supervision that practitioners experienced professional isolation due to lack of support, poor recognition and unavailability of opportunities to discuss and critique clinical issues with their colleagues. The introduction of clinical supervision reduced professional isolation and enabled practitioners to identify support networks.

Satisfactory working environments are considered important in supporting nurses' well-being so that quality care can be provided. In order to examine the impact of working environments, Begat and Severinsson (2006) carried out three studies that focused on work environments to interpret the experiences of nurses' well-being in relation to clinical supervision. The findings indicated that clinical supervision brings about increased awareness of self and that of the work environment.

Some studies have indicated that supervision is not always a positive activity. An investigation to determine factors that promoted or hindered the achievements of multi-professional team supervision indicated that respondents were unclear about the value of clinical supervision (Hyrkas, Appelqvist-Schmidlechner, & Paunonen-Ilmonen, 2002). In the same study, reluctance to participate in clinical supervision was attributed to fear of evoking stress.

Group supervision is often offered as a cost-effective alternative to one-to-one supervision. There are perceived benefits of clinical supervision resulting from group processes. Berg and Hallberg (1999) investigated the effects of systematic group clinical supervision and supervised individual planned care on 22 nurses on a psychiatric ward. They used a pre-post-test design over a period of one year to ascertain nurses' sense of coherence, creativity, strain and job satisfaction. Data was collected before the beginning of the study and then at six months and 12 months after the intervention. Four validated questionnaires were used to collect the data, including some statements of the nurses' views of the effects of clinical supervision. The findings were variable; indicating improvement in creativity and innovativeness but no improvements with nurses' satisfaction with nursing care and work related strain. There were personal and emotional conflicts that were attributed to inadequate

organisational supports and the time frame allocated for the study. A parallel qualitative study with the same group of nurses elucidated their lived experiences in terms of the meaning and significance of systematic clinical group supervision combined with supervised individually planned care. The nurses' views of the effects of supervision were that there was increased cooperation among the nurses as well as an increase in personal and professional development.

A similar qualitative descriptive study investigated 10 psychiatric nurses' perceptions of the influence of group supervision on their professional competence. The findings indicated that the nurses acquired more knowledge and self confidence and that they felt increased job satisfaction and personal development (Arvidsson, Lofgren, & Fridlund, 2001). Continued supervision was considered essential and enabled the nurses to integrate theory and nursing practice. Group supervision is further explored under the theories and models of supervision section in this chapter.

### ***2.5.2 Benefits for clients***

Clinical supervision has potential benefits not only on practitioners but also indirectly for clients. A quasi-experimental controlled study compared and evaluated mental health nurses who were undertaking training in psychosocial interventions and the effect of this on client outcomes (Bradshaw, Butterworth, & Mairs, 2007). Outcomes of the training on clinical practice were compared between nurses who received the psychosocial training plus workplace clinical supervision against those who received training but no clinical supervision. The results showed that nurses who had received workplace supervision had greater knowledge of psychosocial interventions compared to the nurses who did not receive supervision. Clinical improvement of clients was observed to be greater in the clients who had worked with nurses from the experimental group. The results support the formative function of supervision (Proctor, 1986).

A study to determine patient satisfaction in a quality improvement programme combined with team supervision and staff self assessments found that continuous self-assessment by the nurses and feedback from patients improved the quality of care. The feedback mechanism helped staff to identify areas requiring improvement by highlighting their strengths and weaknesses (Hyrkas & Lehti, 2003).

## **2.6 Resources for supporting clinical supervision**

Training in clinical supervision has the potential to clarify the misconceptions about supervision as well as provide better understanding of supervision. The availability of supervision training and the frequency of supervision sessions have an impact on the outcomes of clinical supervision (Barriball et al., 2004). According to Hyrkas (2005) shortage or absence of training affects the outcomes of supervision. The value of training is corroborated by a study of seven sites across a National Health Service Trust in the United Kingdom in which training of both supervisors and supervisees enabled structured supervision to occur (Bedward & Daniels, 2005). In this study, it was found that training and peer support reduced professional isolation.

Time and regularity of clinical supervision sessions impact on the outcomes of supervision. In a survey of 815 community mental health nurses in Wales, practitioners who attended supervision for between 45 minutes and an hour at least once a month found clinical supervision to be more effective compared to nurses whose supervision was less regular (Edwards et al., 2005). The authors recommended the need for organisational supports that ensure that clinical supervision occurred regularly and for at least an hour at a time.

Investing in clinical supervision has a cost-benefit effect to organisations, nurses and clients. A study conducted by Hyrkas, Lehti and Paunonen-Ilmonen (2001) to determine the cost effectiveness of clinical supervision in a Swedish hospital found that the cost of the nurses' time and cost of the supervisors was low and cost effective. There was a reduction in client complaints and sick leave, increased client satisfaction and increased knowledge.

## **2.7 Theories and models of supervision**

Approaches to clinical supervision are often guided by theoretical frameworks that are then translated into practical activities (models) within the supervisory relationship. The application of the models is variable in focus and mode of delivery. Literature suggests that the common themes of the models are around education, support, professional development and quality assurance. However, the application of any model is influenced by a number of factors, including professional discipline, purpose and cultural contexts (Cleary & Freeman, 2005; McKenna et al., 2008). Models of supervision are thus adapted to suit specific groups and individuals (Stevenson, 2005). Over the last two decades a large number of models have

been developed with origins in counselling and psychotherapy (Bernard & Goodyear, 1998). For the purpose of this study I have narrowed and described the focus, models and frameworks that have been mostly adapted into nursing.

### ***2.7.1 One to one supervision models***

A model of counselling supervision developed by Proctor (2001) described a one to one process that covered three functions of clinical supervision. Known as the three function interactive model (Proctor, 1988), this model is widely used in nursing supervision (Winstanley & White, 2003). The formative function of Proctor's model relates to the acquisition of skills and knowledge through reflection and identification of practices that facilitate learning. The formative function enables ongoing learning. According to findings of a thematic review of nurses' quality of care, nurses reported an increase in personal, theoretical and shared knowledge (Hyrkas & Paunonen- Ilmonen, 2001). The restorative function of the model provides support in relation to personal and emotional issues such as stress, isolation and burnout that arise in supervision. Restorative support reduces professional isolation (Bedward & Daniels, 2005) and burnout (Teasdale et al., 2001). The normative aspect of supervision relates to the supervisee's awareness and adherence to institutional goals and processes. These may include policies and procedures, ethical dilemmas, regulatory and professional standards in order to maintain quality standards of care. In a study to evaluate the effectiveness of Proctor's model indicated that the nurses benefitted from each of the model's dimensions (Bowles & Young, 1999). The authors reported that the model is also easy to understand and practical.

A weakness of Proctor's the model is the lack of clarity about what supervisor interventions are required to meet the requirements of each of the domains (Sloan & Watson, 2001). The model is a theoretical statement that does not consider clinical outcomes of clinical supervision or organisational factors affecting clinical supervision (Buus & Gonge, 2009). Buus and Gonge (2009) suggest that the model be extended and refined so that it can cover the dynamics that occur between tasks and roles and between clinical and organisational factors.

Heron's (1989) model focuses on interpersonal relationships within the helping professions. It is a one to one process that explores issues around work, discipline, career guidance or personal matters. The model has been adapted for use in nursing and other

professional groups (Sloan & Watson, 2001). The framework has six categories; prescriptive, informative, confronting, cathartic, catalytic and supportive which are further subdivided into two approaches: authoritative and facilitative (Sloan & Watson, 2001). Authoritative approaches put the supervisor in control of the relationship whereas facilitative approaches allow control to remain with the supervisee. The application of each approach in supervision is determined by the context in which supervision occurs and the developmental stage of the supervisee. Heron (1989) asserted that:

Authoritative interventions are neither more or less useful nor valuable than facilitative ones. It depends on the nature of the practitioner's role, the particular needs of the client and what the content or focus of the intervention is. It is the specific concrete context that makes one intervention more or less valuable than another. (p. 12)

Heron explained these approaches to illustrate how the supervisor can apply each category accordingly: prescriptive interventions are intended to influence and direct behaviour by offering advice and suggestions; informative interventions involve providing information and resources to impart new knowledge; confronting interventions challenge rigid ways by telling the unwanted truth; cathartic interventions assist with facing difficult emotions; catalytic interventions encourage self exploration and problem solving and supportive interventions offer encouragement and validation.

Heron's six category intervention analysis is applicable as a model in clinical supervision due to the transferability of its interventions to nursing situations and practices. However this fluidity means the framework can be used beyond clinical supervision and this has led to confusion about its true purpose. Research on the application of the six categories found contradictory results regarding the mostly used categories. The model also raised concerns in that though the interventions can be helpful, it needs to be acknowledged that supervisors can unwittingly use unhelpful unsolicited, manipulative, compulsive and unskilled use of strategies without seeking agreement from the supervisee (Sloan & Watson, 2001). Supervisors need to seek agreement from supervisees before such interactions take place.

### ***2.7.2 Group supervision models***

Group supervision, is a model that has been adopted by mental health nurses. The model involves a number of supervisees and one supervisor. Other variations of group supervision are peer group clinical supervision, telephone clinical supervision and video conferencing.

Due to perceived budgetary constraints in most mental health services group supervision is often seen as an answer to reduce costs while affording practitioners a time to reflect and develop in their practice. A study to identify factors that influence the effectiveness of clinical supervision found that up to one fifth of the 260 respondents had attended group supervision (Edwards et al., 2005). The results showed that there were no significant differences in the effectiveness of clinical supervision between nurses who received one to one supervision and those who received group supervision. According to Clibbens, Ashmore and Carver (2007) group clinical supervision is cost effective. The authors conducted a study in which pre-registration mental health nurses participated in group supervision during three years of a diploma training programme. A group supervision programme was developed using a model adapted from Proctor (1986) and incorporated other elements of group dynamics. The students were supervised by their lecturers who were not connected to the clinical areas. This type of supervision can be cost effective because of the dual role of the supervisors. However, while this arrangement had the benefit of providing continuity for the students, Carver, Ashmore and Clibbens (2007) highlight a potential problem of role conflict for the supervisor who is also a lecturer. According to Hawkins and Shohet (1989) shortage of resources means that the groups are larger than desirable.

Another study described general nursing students' experiences of the effects of group supervision and compared the differences in the responses between group and individual supervision during clinical placements (Saarikoski, Warne, Aunio, & Leino-Kilpi, 2006). A quasi experimental design was used to compare the students' experiences. The experimental group held 90 minute unstructured group supervision sessions weekly with their teacher for five weeks and an individual evaluation session at the end of the placement. The control group held two or three individual sessions with the same teacher but there were no group sessions. The findings revealed group supervision to be an approach that can foster professional identity in students. All the participants in the study felt that group supervision is a more useful approach.

Group supervision has also been shown to be beneficial to registered nurses. Benefits of group supervision include: the generation of support; opportunities to share anxieties with peers; validation; and gaining from experiences of others in the group (Hawkins & Shohet, 1989). Advice and support obtained through group supervision is perceived to be more effective than that received in one to one sessions (Winstanley, 2000). Winstanley (2000) also reports that supervisees found that group supervision put fewer demands on their time compared to one to one sessions. Nurses were able to find time to attend supervision without disrupting their work schedules.

### ***2.7.3 Peer supervision***

Peer group clinical supervision is a variation of group supervision in which there is no identified supervisor. The group is assumed to have the resources to help themselves and to take responsibility for their supervision. Peer group supervision has been used in psychotherapy, nursing education, nursing and nursing management (Lakeman & Glasgow, 2009). A model of peer group clinical supervision developed in Trinidad involved 10 mental health nurses (Lakeman & Glasgow, 2009). The peers facilitated the group sessions and took turns to facilitate and present cases following a prescribed process. They tailored the process to suit their supervisory needs by adopting a suitable format such as formative or restorative pathways. The participants self reported on their experiences. The findings indicated that the nurses found the experience helpful and supportive.

Lakeman and Glasgow (2009) caution that peer group supervision requires strong facilitation skills and commitment. Risks associated with peer supervision are that peers may not challenge each other enough to benefit from the process. Cutcliffe, Butterworth and Proctor (2001) warn that both supervisor and supervisee can share the same blind spot when roles between the supervisor and supervisee are blurred in peer supervision.

### ***2.7.4 Tele and video-conferencing***

Tele and video-conferencing are growing in popularity where distance and practitioner isolation pose problems. In a project aimed at facilitating reflection and professional development for nurses by increasing clinical supervision activity in a Primary Care Trust, nurses and a supervisor used a telephone scheme to contact each other. The nurses had access to a database that prompted them to ask questions and take notes. The project reported



increased interest and expansion, an assumption taken to indicate that the project had been a success (Thompson & Winter, 2004).

Another project used video-conferencing with 40 nurses to facilitate long distance supervision (Marrow, Hollyoake, Hamer, & Kenrick, 2002). Focus groups, pre and post-study questionnaires, repertory grids and written narratives were used to evaluate the project. Findings indicated that rural nurses benefitted from clinical supervision using video-conferencing technology.

### ***2.7.5 Cultural supervision***

Cultural supervision provides opportunities to explore and learn about cultural competence. Kaupapa Maori supervision is a form of cultural supervision that is recognised as important for ensuring the safety, accountability and professionalism of Maori practitioners. Kaupapa Maori supervision involves relationships between members of the same culture with the aim of ensuring that the supervisees practise according to values, protocols and practices of that particular culture. Eruera (2005) described the model that puts together Maori practices and concepts to incorporate skills, knowledge, values, professional and personal experiences. Cultural supervision is about cultural accountability and cultural development.

It should be noted that cultural supervision is separate from cultural consultation in that specific advice about practice is sought from a members of the clients' culture in order to obtain specific advice about practice (Howard, Burns, & Waitoki, 2007; McKenna et al., 2008). Howard, Burns, and Waitoki (2007) noted that the interplay of cultures that can occur between supervisor, supervisee and clients are complex. The supervisor has to explore this complexity and assist the supervisee gain a better understanding of biculturalism and its impacts on clients' outcomes through guided discussions in clinical supervision.

### ***2.7.6 Multi-professional supervision***

The advent of multidisciplinary team practices has influenced the development of systems of clinical supervision that focus on broader aspects of client care. Therefore, supervision can take a shared approach that emphasises multi rather than uni-professional focus (Farrington, 1995b).

Butterworth and Faugier (1992) recommended that multi-professional supervision is one way of organizing clinical supervision for nurses. Although there are some reservations

about this concept, Mullarkey, Keeley and Playle (2001) argued that multi-professional supervision can reduce costs associated with resources. Nurses working in multidisciplinary teams are more likely to have a closer alliance with practitioners from another profession than their own and may wish to receive supervision to meet particular needs other professionals offer.

Mullarkey, Keeley and Playle further argued that multi-professional supervision promotes collaboration and co-operation through shared philosophies and practices within the context of multidisciplinary working. This argument has been supported by Ovretveit (1993) who stated that multi-professional work aims to maintain collaborative links and participation. It provides support that can result in high performance and increased quality of care.

Some professions, including nursing, argue that multi-professional supervision undermines the development of individual professions. While these concerns are acknowledged, the arguments might be a reflection of defensiveness and professional insecurities on the part of different professions (Mullarkey et al., 2001). Kelly et al. (2001) argued that nurses can successfully be supervised by other disciplines. However, as suggested by Page and Wosket (2001) the essence of effective supervision lies more in the compatibility of the supervisor and supervisees' philosophies and approaches. The choice of supervisor should not be dictated by profession. Furthermore, the contradictions and differences in the research, theory and practice of clinical supervision between disciplines does not favour shifting the learning and practising supervision from one profession to the other (Buus & Gonge, 2009; Yegdich & Cushing, 1998).

The purpose of models is not to be prescriptive but to act as guides. Imposition of models may work against the flexibility that is required within different contexts. Mullarkey et al. (2001) suggest that supervisors and supervisees need to develop approaches to clinical supervision that suit their individual or team needs. Some models of clinical supervision blur the distinction between supervision and therapy. In addition there is often a blur between clinical supervision and managerial supervision. This confusion has marred effective supervision and needs to be considered when selecting models to use in clinical supervision.

## **2.8 Conclusion**

An outline of the key concepts of clinical supervision including the current context of clinical supervision in New Zealand, definitions of clinical supervision, the purposes and effectiveness of clinical supervision have been provided in this chapter. Some supervision models commonly used in mental health nursing have been described. The next chapter presents a literature review of clinical supervision with special emphasis on experiences and roles of clinical supervisors.

## **CHAPTER THREE: LITERATURE REVIEW**

### **3.1 Introduction**

In the previous chapter, clinical supervision was discussed in regard to its definitions, applications, benefits and models. Relevant literature was reviewed in relation to these subjects. Attention was also given to clinical supervision in the New Zealand context. This chapter focuses specifically on literature about the role of the clinical supervisor. In particular it identifies what is known about providing clinical supervision within mental health and addictions nursing. Literature on other nursing specialties, psychiatry and allied health professions is also included in order to contextualise the study.

This chapter is presented in three sections. It begins with an explanation about the search strategies used to identify literature on supervision and supervising. It continues with a review of literature on supervisors. Within this section, training and support for supervisors, the ideal attributes and characteristics of clinical supervisors, and barriers to supervision are presented. The chapter concludes with a discussion of the literature on clinical supervision in New Zealand context and identification of the gap to be addressed in the current study.

### **3.2 Literature search strategy**

Literature was accessed through searches of Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PsychInfo databases. The internet search engine Google Scholar was another medium through which literature was accessed. Manual searching of major mental health nursing journals; *International Journal of Mental Health Nursing*, *Journal of Advanced Nursing*, *Journal of Psychiatric and Mental Health Nursing*, and *Journal of Psychosocial and Mental Health Nursing*, was also conducted. Local literature was accessed through the New Zealand Ministry of Health, Te Pou and NCNZ web pages. Citations identified in articles from the above searches were also used to supplement the manual and database searches. The following search terms were used in various combinations: clinical supervision, professional supervision, clinical supervisor, mental health nur\*, psychiatric nur\*, mental health, mental health professional, mental health service\* and psychiatric departments. Literature on clinical supervision for health is vast. Abstracts of relevant papers were read to identify their focus to the topic. On that basis,

publications were prioritised and literature search was therefore narrowed to focus on areas of practice in supervision, ethical issues, characteristics of supervision and supervisors and outcomes of supervision in mental health nursing and other New Zealand health disciplines.

### **3.3 Literature on clinical supervisors**

A review of the literature on clinical supervisors found that it focuses on three areas: training and support needs of supervisors, attributes and characteristics of supervisors and barriers to clinical supervision. These will be discussed below.

#### ***3.3.1 Training and support for clinical supervision***

Training is considered by most authors as an essential preparation for the clinical supervision role (Bond & Holland, 1998b; Wilson, 1999). Scanlon (1998) advocated for training and education that would equip nurses with skills to make positive changes, otherwise the benefits of supervision would not be realised (Gilmore, 1999). Similarly White et al. (1998) noted that clinical supervisors require skills before they can begin supervising. However, a survey of community mental health nurses' perceptions of clinical supervision conducted by Kelly (2001) showed that while the respondents supported the importance of training in clinical supervision, there was a significant number of supervisors who had no formal training. Cutcliffe (1997) noted that inadequate supervision training affects the quality of supervision outcomes.

Jones (1998) described a training method that allowed nurses to develop the skills and competencies required for developing productive working relationships in clinical supervision. Outcomes of the training were that future procedures for introducing clinical supervision mirror qualities required for developing effective nursing relationships. Jones (1998) also advocated for the recognition of the supervisors around provision of information on available supervision expertise via a network directory to encourage an exchange of ideas.

Training and preparation has been highlighted in a study that evaluated the implementation of clinical supervision within a learning disability setting in which participants realised that training improved communication among the members (Malin, 2000). In this setting, education and preparation for clinical supervision assisted the

supervisors “to engage with the process and to understand the concepts involved” (Malin, 2000, p. 555).

Hancox, Lynch, Happell, and Biondo (2004) conducted a study to evaluate an educational programme for clinical supervision in which 63 mental health nurses participated. The programme had been developed with the aim of enhancing theoretical knowledge and skills on supervision models, the benefits, legal and ethical dilemmas and to develop intervention strategies on clinical supervision. The findings revealed that over 80 percent of the respondents developed increased levels of confidence in providing supervision and considered doing further study in clinical supervision. There was a more positive attitude to receiving and providing clinical supervision. The evaluation concluded that without education and training, there is a risk of nurses developing unhealthy supervisory relationships.

Milne and James (2002) studied the impact of training on competence in clinical supervision for psychologists. The findings revealed the need for training in order to ensure competence. In this longitudinal study of one supervisor and six supervisees, 1,387 interactions were examined and coded using an evaluation instrument to analyse the effect of training in clinical supervision. The study involved four phases; baseline, first intervention phase, second intervention phase and maintenance phase and evaluations were done throughout the four phases. Supervisor competence was noted to be poor at baseline but increased over time. Supervisees’ satisfaction with supervision was also rated and findings were that supervisees rated their supervisor to be most competent in the maintenance phase. A randomised controlled trial of allied mental health practitioners evaluated the effects of supervision training of supervisors and supervisees (Kavanagh et al., 2008). The trial compared the effects of immediate training of supervisors against delayed training of supervisees over a three month period. The trial also tested the need for training of both supervisors and supervisees. Findings indicated that the limited time frame of three months limited the evaluation of any potential changes in the sessions. Benefits of supervision were subjectively reported more by supervisors than supervisees. Training both supervisors and supervisees at different time intervals reduced efficacy of the supervisors and was found to be ineffective. The authors recommended that simultaneous separate training of supervisors and supervisees would address this problem.

Using qualitative and quantitative data collected from 115 supervisees, 71 supervisors, 170 patients and 17 senior managers, a recent randomised trial conducted in 17 mental health facilities in Australia looked at the impact of clinical supervision on quality of nursing care and client outcomes (White, 2010). Supervisors revealed that their performance was affected by the culture of the organisation in terms of support or lack of it. Supervisees reported that their supervision experiences were of high standard and that they had benefitted from supervision as evidenced by increased function in their normative and restorative domains. A positive relationship between supervision, quality of care and patient outcomes was not statistically significant except in one location.

Support and supportive environments can assist supervisors to monitor and improve their performance and practice. Supervisors require their own supervision as this support and feedback enhances further development of their skills (Severinsson & Hallberg, 1996b). This finding is supported by Spence et al. (2002) who noted that supervisors need support networks. Supervisors also need open and constructive forms of feedback in order to facilitate their development (Price & Chalker, 2000).

According to Jones (2006) supervising groups increases supervisors' anxiety levels. Therefore, supervisors require support. A study to describe the experiences of supervisors of groups noted that "supervisors need to constantly develop new strategies" for the improvement of supervision through continuous support (Eriksson & Fagerberg, 2008, p. 881). Erikson and Fagerberg noted that the demands of group supervision meant that the supervisors were in an exposed position that required their role to be acknowledged while affording them opportunities to develop abilities and skills. Being acknowledged assisted the supervisors to gain control of their exposed and vulnerable situations (Eriksson & Fagerberg, 2008).

A Norwegian study of nurse supervisors' ideas and experiences in relation to student supervision concluded that the supervisors themselves have explicit needs. These needs are related to application of theory to practice, role functions and organizational framework factors. The nurses felt the need for recognition of this responsibility and to have clearer definitions of role expectations (Landmark, Hansen, Bjones, & Bohler, 2003).

Literature reviewed suggests that education and training are considered important to ensure that supervisors are competent to provide clinical supervision otherwise there is a risk

of unhealthy supervisory relationships and poor supervision outcomes. Support and feedback are essential components to enable clinical supervisors to enhance development of their skills.

### ***3.3.2 Attributes and characteristics of good supervisors***

Several studies have identified the desirable roles and attributes of clinical supervisors. The studies suggest that in addition to skills and knowledge that enable supervisors to support other's professional development, other supervisor characteristics and attributes are necessary to enhance growth for the supervisees.

#### *Provision of education and support*

Through education, supervisees develop skills to problem solve, manage risk and share information. Good supervisors are perceived to be able to provide support, provide relevant literature and encourage supervisees to apply new skills in their practice (Worthington & Roehlke, 1979). A survey of the experiences of clinical nurse specialists in mental health found that good supervisors were competent in providing specific ideas about interventions and giving feedback, promoting autonomy, and were supportive (Pesut & Williams, 1990). The concept of clinical supervision as a means of providing support to supervisors was highlighted as complementary to professional development (Bulmer, 1997).

#### *Facilitation of reflection and learning*

Supervisors require facilitation techniques to enhance supervisee growth. They also require environments that are conducive in order to focus on the reflective process of supervision. By facilitating reflection, supervisors permit the exploration of theoretical and practical aspects of nursing practice thereby improving performance. Arvidsson and Fridlund (2005) examined 141 critical incident reports of 25 nurse supervisors using a qualitative descriptive approach. The aim was to identify any factors that influenced the competency of the supervisors. The authors found that supervisors exhibited personal and professional viewpoints through self examination and creation of environments that promoted reflection and learning. They also found that the supervisors sometimes lacked self-assurance and required their own supervision to address this. Clinical supervision was perceived to be beneficial for enhancing professional development through reflection. According to Kilcullen (2007) reflection helps nurses to feel supported, increase self awareness and enable them to link theory with practice.



### *Motivation and commitment*

Motivation and commitment are perceived to be important attributes in clinical supervision. Price and Chalker (2000) highlighted both commitment and motivation as important attributes for supervising as well as for being supervised. Wilson (1999) also agreed that commitment by the supervisor and supervisee is essential in order for effective supervision to take place. According to Severinsson (1996) supervisors' wishes to increase knowledge and skills in the nursing profession and to raising the quality of care are a motive for becoming a supervisor.

### *Supervisor attributes*

Personal qualities and competence are important supervisor characteristics. In a blend of qualitative and quantitative methods, Fowler (1995) explored supervisees' perspectives of the characteristics of good supervisors. The findings indicated that supervisees expect their supervisors to be supportive and to have relevant knowledge and clinical skills. Bulmer (1997) articulated the skills and characteristics rated in supervisors as; "trust-worthiness; openness and honesty; having good listening and analytical skills; being supportive; giving constructive criticism; facilitative; accepting limitations; providing positive feedback and being non-judgemental" (p. 54).

In a qualitative study of characteristics of good supervisors for community mental health nurses Sloan (1999) identified 10 important characteristics. These included the supervisor's abilities to be good role models, to form and provide supportive relationships and to possess relevant knowledge base and clinical skills. Commitment, good listening skills and acknowledgement of limitations were also viewed as important (Sloan, 1999). These characteristics were similar to some that were identified in earlier studies (Fowler, 1995; Worthington & Roehlke, 1979).

### *Flexibility and credibility*

Flexibility was described as the ability to demonstrate active leadership as the supervisor navigates various roles in response to different supervisee needs. As reported by Eriksson and Fagerberg (2008) supervisors are meant to have the ability to understand and to adopt roles to suit different situations. A descriptive correlational study of two groups of nurse supervisors found that the nurses' styles varied in their use of models, theories, and in their perceptions of ethical dilemmas during supervision (Begat, Berggren, Ellefsen, & Severinsson, 2003). The results showed that nurses used different theoretical approaches and models and that the

organization of clinical supervision depends on different contexts. While other theories such as human development theory; psychodynamic theory and pedagogical theory were mentioned, most participants in the study preferred a particular model based on reflective theory. This finding supports Todd and Freshwater (1999) who pointed out that there are no agreed upon models of supervision and Hykras, Koivula and Paunonen (1999) whose recommendations called for the need to use theories to underpin clinical supervision. In a study exploring supervisor leadership styles and personal qualities of 18 nurse supervisors, Severinsson and Hallberg (1996a) identified that the supervisor role was a complex one that required application of different styles. They noted that the abilities of the supervisor to affirm supervisees' professional practice and to exhibit genuine feelings during supervision were important. Their findings also showed that supervisors place high values on techniques of clinical supervision in the facilitation of learning and in creating environments conducive to learning. Credibility emanates from the supervisor placing him or herself at the same level as the supervisee without being seen as a total outsider or being too analytical (Hyrkas et al., 2002).

#### *Ethical and moral responsibilities*

The development of supervisees' job identities, competence, skills and ethics can be influenced by the supervisor's competence and moral responsibility. Sharing thoughts and meanings experienced in the supervision, confirmation and self-awareness requires supervisors to possess qualities and competencies that can enable them to facilitate supervision dialogue (Severinsson, 2001).

Berggren and Severinsson (2003) conducted a focus group to elucidate supervisors' ethical approaches and decision making approaches during clinical supervision. The findings indicated that personal integrity and autonomy were utilised during supervision to enhance the quality of nursing care. The supervisors' decision-making styles and interventions influenced the outcomes of supervision. Sharing of knowledge and ethical principles around patient care created a strong sense of professional identity.

A study of general nurse supervisors' and supervisees' experiences of clinical supervision yielded positive and negative aspects of clinical supervision as well as factors that impacted on clinical supervision (Kilcullen, 2007). Negative aspects were attributed to

lack of adequate information about clinical supervision and the absence of formal systems that would provide support.

Supervisor attributes and characteristics influence the quality of supervision. Supervisors contribute to quality supervision when they create supportive environments, provide feedback, affirmations for supervisees and facilitate reflection and learning. Flexibility and trust-worthiness are essential. Supervisors act as role models who contribute to the creation of professional identity. When implementing clinical supervision, DHBs should take into account that supervisors are motivated individuals who are committed to increasing nursing knowledge and to raising the quality of nursing care.

### **3.4 Barriers to clinical supervision**

Several factors have been found to impede the implementation of supervision. Barriers include costs of training and support for supervision in terms of human resources and time; lack of clarity with separating managerial and clinical supervision; and lack of clear guidelines; power dynamics between the organisations, supervisors and supervisees that creates suspicion and resistance.

There are various opinions as regards the cost benefits of implementing clinical supervision. Lyth (2000) reported that problems with full implementation of effective supervision training has been attributed to high costs. White and Winstanley (2006) however argue that the benefits of clinical supervision in reducing staff burnout and well being outweigh the costs, and that the costs should not hinder the establishment and running of clinical supervision programmes. The authors found that the cost of one to one supervision was equivalent to about one percent of the supervisor's annual salary. This argument supports an earlier view that reduced sick leave, reduction in complaints and errors, improved quality of care and increased staff morale means that the initial costs of implementing supervision can be absorbed and that supervision can pay for itself (Nicklin, 1997). Cutcliffe and Proctor (1998) recommend the introduction of clinical supervision into the nurse training curriculum to save costs later on. Early introduction of clinical supervision equips nurses with the concepts of supervision while they are still young in the profession (Proctor, 2010).

Confusion between managerial and clinical supervision has tended to blur the purpose of supervision. Suspicion arises when the supervisor is a line manager due to possible confusion of roles and conflict of interest. A survey of stakeholders which explored the implementation of clinical supervision identified a number of factors impeding the process of clinical supervision. One particular constraint to effective clinical supervision was the difficulty encountered in attempting to separate clinical supervision from managerial supervision (Farrington, 1995a; Rice et al., 2007). Malin (2000) examined the role of supervisors and found that while supervisors felt confident and enthusiastic about sharing knowledge, they were unclear about delving into management issues. The ambiguity between management issues of quality control and the normative aspect of clinical supervision as described by Proctor (1986), was also echoed in a qualitative study that explored perceptions and experiences of clinical supervision for mental health nurses (Scanlon & Weir, 1997). Supervision focused on caseload reviews and training requirements and was provided in a top-down approach by line managers or by a consultant psychiatrist (Rice et al., 2007).

The notion of clinical supervision as a form of risk management and surveillance poses potential barriers. Supervisors who are required to link clinical supervision to risk focused organisational audit practices find this practice to be stress provoking and can place supervisory relationships at risk (Grant & Townend, 2007). A survey of clinical supervision practice in Northern Ireland revealed that a lack of clear guidelines and models of supervision to assist with implementing and evaluating clinical supervision are barriers to its implementation (Rice et al., 2007). Rice et al. also identified and recommended the need for adequate human and financial resources, regional guidelines to guide the supervision process, a mixture of models, supervision to be supervisee-led and facilitation of development and education. The study also recommended the need for supervisors to possess theoretical and clinical skills necessary to guide reflection. The findings of the survey are similar in most parts to those reported in a review of approaches to professional supervision in New Zealand and internationally (McKenna et al., 2008). In their report, McKenna et al. indicated that scarcity and the quality of supervisors; time and workload constraints; unsuitable environments in which to conduct supervision and resistance by some nurses to engage in supervision were barriers to supervision. They recommended the development of national guidelines and a national training structure that focused on administrative, educative and supportive functions rather than specific supervision models.

Interpersonal and inter organisational dynamics can affect the outcomes of clinical supervision. Cottrell (2002) described the dynamics between the organization, managers, supervisors and supervisees that can impact on the implementation of clinical supervision. The exchanges between the members can create suspicion, resistance, tokenism and mutiny. According to Cottrell (2000) suspicion arises when there are no clear guidelines around content of supervision or with what happens to the information discussed in supervision. Resistance can occur if staff feels disempowered and perceive the organization to be overly controlling. Tokenism involves supervision that may be superficial in response to perceived authority rather than personal interest and choices in the supervision process. Mutiny relates to supervisors and supervisee 'doing their own thing' with disregard for the needs of the organization and clients. With no clear directions or guidelines, supervision is often a mandated tick box exercise.

The implementation of clinical supervision can be constrained by costs especially in an environment where organisations are being asked to cut costs. By not prioritizing clinical supervision and allocating enough resources, organisations run the risk of minimising the impact that clinical supervision brings to mental health nursing. The confusion between managerial and clinical supervision and lack of clear guidelines and procedures often pose challenges and uncertainty as to the true purpose of clinical supervision in.

### **3.5 Clinical supervision in New Zealand**

There are few studies that focus on mental health and addictions nurse clinical supervisors in New Zealand. Most literature on mental health exists in the form of policies and reports that are produced by the Government, DHBs, NGOs and professional bodies. Some research has been conducted by other nursing disciplines such as midwifery as well as by non-nursing professions including social work, counselling, occupational therapy, psychology and dietetics.

One of the most recent and significant studies is a review to investigate current approaches to clinical supervision internationally and for mental health and addiction nurses in New Zealand DHBs and NGOs (McKenna et al., 2008). A survey method was used with managers, supervisees and supervisors to establish how clinical supervision was provided. The survey revealed the need for staff and management commitment to clinical supervision

and provided the following recommendations: development of national supervision guidelines; development of a national training structure for supervision which aligns with *Let's Get Real Framework* (Ministry of Health, 2008). The training would focus on the structure of supervision rather than being model specific; development of accreditation processes; development of a national database of trained supervisors, and research based evaluations of clinical supervision. As a follow through to the recommendations, a set of guidelines were developed to ensure consistency and to set a national standard for implementing and sustaining clinical supervision in New Zealand (Te Pou, 2009). The guidelines discuss the context, description and definition in which clinical supervision takes place, outlines the steps to be taken in conducting clinical supervision, the roles, responsibilities and relationships of all parties concerned and details of how to implement clinical supervision within organisations.

In response to the recommendations of the review of clinical supervision for mental health and addictions nurses undertaken by McKenna, Thom, Howard and Williams (2008) and the national guidelines developed by Te Pou (2009), a pilot study was conducted to develop supervision training for supervisors and supervisees (Te Pou, 2010). The professional supervision training programme was developed and piloted in Northland District Health Board with a group of supervisors and supervisees for six months (Te Pou, 2010). The aims of the project were to undertake training and implement professional supervision that would then be evaluated to determine: satisfaction with the training process and content; the impact of training on supervision practice; benefits of supervision and the strengths, barriers and limitations of supervision with a view to make recommendations. Both supervisors [n=15] and supervisees [n=18] received training that included supervision skills and theory. Eleven supervisors and 16 supervisees proceeded with supervision. The programme was evaluated using pre and post workshop questionnaires, mid-way and final questionnaires, focus group discussions and telephone interviews.

The Northland evaluation revealed that both supervisees and supervisors found supervision training in the theory and practice of supervision useful. Participants reported that the content of supervision reflected educative, administrative and supportive functions of supervision and the role of the supervision co-coordinator was important. Clinical skills, confidence, ethical awareness, and knowledge base were increased and relationships with colleagues improved in both supervisors and supervisees. Clinical supervision outcomes for

service users and the organisation were not evaluated, however the assumption made was that the benefits identified by the supervisors and supervisees would impact on the service as a whole in terms of risk management and adherence to policy and procedures. Participants recommended the implementation of clinical supervision nationally and emphasised the uniqueness of different organisations while acknowledging the existence of core skills. Support with resources and supervision training were identified as strengths while negative attitudes by individuals and managers, and inadequate or unsuitable supervision environments were identified as barriers and limitations of the project.

The impact of clinical supervision on mental health nurses' relationships with consumers was investigated in a qualitative New Zealand study. Recommendations were that supervision should not be hierarchical in nature and that training of supervisors should be consistent and ongoing to enable them to effect meaningful changes in practice (Mernick, 2009).

Although there are few studies on mental health and addictions nurse clinical supervisors, there have been studies about clinical supervision in other nursing specialties and in allied professions including mental health support workers. A review of this broader literature is provided below in order to gain insight into some of the key issues around clinical supervision in New Zealand. Most of these studies focus on supervisory relationships.

One study examined the link between clinical supervision and clinical governance (Cooper & Anglem, 2003). The study compared the outcomes of clinical supervision of nurses and allied health practitioners of two different health services and also explored the effectiveness of clinical supervision. Because the study did not specifically target nurse clinical supervisors it was difficult to evaluate the impact of clinical supervision in nursing. The findings indicated that clinical supervision increased the participants' confidence. Choosing one's own supervisor as well as the quality of supervisor and supervisee relationship was rated as important.

Mental health nursing is carried out as part of team work of a variety of professionals in order for them to meet the different needs of clients. It could be argued therefore that interdisciplinary supervision would meet mental health nurses' needs. A study of an interdisciplinary supervisor development involving district nurses and allied health practitioners in home and older adult services concluded that interdisciplinary supervision

was one way to address “ hierarchical models of nursing supervision” (Rains, 2007, p. 65). Supervising groups provided a supportive environment in which to discuss, reflect and practise supervision skills. The method facilitated networking, learning and communication across disciplines.

Davys and Beddoe (2008), in their study on inter-professional supervision training of 12 participants from nursing, physiotherapy, speech therapy, social work, teaching, dietetics and medicine found that the professional differences between the supervisors improved communication and enhanced learning. Davys and Beddoe also reported that supervisor training is a generic process and that the success of inter-professional supervision lies in the use of models that apply across all the disciplines. Interprofessional clinical supervisor training enables practitioners to receive cost effective training and provides opportunities for organisations to develop policies and practices that are consistent across professional groups (Davys & Beddoe, 2008).

A recent study of six experienced social work supervisors explored supervision practice in relation to perceived surveillance of professionals through regulatory activities and the linking of supervision to quality and accountability (Beddoe, 2010). Findings suggest that supervisors are under pressure in order to avert risk. The author suggests that supervisors need to strengthen and conform to the principles of supervision, including reflective learning rather than promote surveillance of professional practice.

Sutcliffe (2007) conducted a study of mental health support workers to uncover their experiences of receiving clinical supervision. Although the participants were not registered mental health professionals, their work involved supporting people who are recovering from mental illness. Participants indicated that effective supervision is based on trust and mutual respect and on supportive supervisory relationships that contributed to personal, cultural and professional identity. The study concluded that supervision is a dynamic process that involves the client, support worker, supervisor and the organisation and that it is critical for the safety of clients, the professionals and support workers.

Herkt (2005) explored the nature and process of supervision of occupational therapists who were providing and receiving supervision. The study revealed that supervision was strongly aligned with performance management with a greater focus on competence. The



study also found that the quality of supervisory relationships were important to outcomes of supervision.

While there are an increasing number of midwives accessing clinical supervision, there are very few studies focusing on clinical supervision in midwifery. One thesis study that looked at burnout among independent midwives also focused on supervisory relationships (Smythe & Young, 2008). The findings indicated that independent midwifery is stressful and that clinical supervision was valuable as a strategy to prevent burnout by enabling midwives to have a safe place in which to reflect on practice, to identify early warning signs of burnout and the strategies to deal with them.

There are a growing number of dieticians who are giving and receiving clinical supervision in New Zealand. A recent study of 20 senior dieticians with experience as supervisors investigated their experience of supervision and its value in practice (Paulin, 2010). Supervision was found to have a supportive function with opportunities for practitioners to reflect on practice and that clinical supervision was linked to professional development.

New Zealand literature conducted in nursing, midwifery, social work, occupational therapy and mental health support work has revealed emphasis on the quality of supervisory relationships as important in promoting professional development and to enhance quality of care. Furthermore, several reports indicate that interdisciplinary and inter-professional supervision are cost-effective strategies that provide opportunities for networking, communication and learning. Mental health nursing literature has revealed variability in the way clinical supervision is implemented by DHBs and NGOs.

### **3.6 The gap in literature**

Literature on clinical supervision has tended to focus on findings from the perspectives of supervisees and managers. There is little research from the perspectives of those providing clinical supervision and in particular from mental health nurses (Severinsson & Borgenhammer, 1997; Severinsson & Hallberg, 1996b). Eriksson and Fagerberg (2008) pointed out that studies that of supervisors focused more on the structure of supervision rather than on how the supervisors experience supervision.

There are few studies that focus on supervisors' experiences in New Zealand. The findings from the survey conducted by McKenna et al.(2008) highlighted the expectations of supervisor roles but does not explore the supervisor experience in depth. This current study intends to complement, in particular, Part Three of Te Pou guidelines on supervision by illuminating insider perspectives of the supervisors. This study will also complement the findings of the pilot study in Northland DHB by describing in depth the experiences of mental health and addictions nurses who provide clinical supervision within another DHB in New Zealand.

### **3.7 Conclusion**

This chapter has presented national and international literature about clinical supervision with particular reference to the role of supervisor. The chapter described specific literature focusing on clinical supervisors including training and support needs, supervisor attributes and characteristics and barriers to supervision. New Zealand studies focusing on mental health nursing were described. Literature from other nursing disciplines and allied health was also discussed.

The review of literature has revealed that there is limited literature focusing on the experiences of mental health nurse clinical supervisors in New Zealand. The studies reviewed highlight the need for more research to investigate the experiences of being a clinical supervisor in mental health and addictions service.

The next chapter will describe the research methodology chosen to answer the research question, "What is the experience of mental health and addictions nurses who provide clinical supervision in a New Zealand DHB?" A qualitative descriptive methodology has been employed to investigate the experiences of the nurse supervisors.

## **CHAPTER FOUR: RESEARCH METHODOLOGY**

### **4.1 Introduction**

In chapter three, a review of literature that emphasises the role of clinical supervisors and the barriers has been described. This chapter describes the research design of the study. It begins by highlighting the aims and objectives of the study, and an overview of qualitative research designs. It then specifically describes the theories that inform qualitative descriptive design. The sampling approach, data collection and analysis techniques are also described. A discussion of the ethical issues and how the study was considered and approved by the University of Auckland and by the local service ethical committees are included.

### **4.2 Aims**

The aim of the study was to explore and describe the experiences of mental health and addictions nurses who provide clinical supervision within a New Zealand District Health Board.

Objectives of the study were:

1. To describe the factors that influence mental health and addictions nurses to take on the role of clinical supervisor
2. To explore how clinical supervisors link previous clinical supervision experiences to their current roles and expectations
3. To describe how clinical supervisors deal with the various tensions arising during supervisory relationships
4. To identify how current New Zealand frameworks, regulations, and DHB policies affect the practice of clinical supervision
5. To identify supervisor needs and how these are met or not met.

### **4.3 Qualitative research design**

Undertaking qualitative research requires the researcher to come up with research processes that can best answer the research question (Sandelowski and Barroso, 2002 as cited in Crotty, 1996). In order to answer the research question “What is the experience of mental health and addictions nurses who provide clinical supervision in a New Zealand District Health Board?” the qualitative research design was deemed to be the best framework (Sandelowski, 2000). The examination of human experiences and provision of thick descriptions of such experiences can be achieved by qualitative methodology.

Qualitative research is described as suitable for the study of human experience in nursing and has increased in use over the last three decades (Schneider, Whitehead, Elliott, LoBiondo-Woods, & Haber, 2007). In recent years researchers have come to realize that quantitative approaches alone discounted certain knowledge that was useful in understanding comprehensive aspects of individual cases within the nursing discipline (Thorne, Kirkham, & MacDonald-Emes, 1997). Chambers (1998) argues that while it is possible to use randomised controlled trials to make generalisations about nursing interventions and outcomes, researchers in the field of mental health would rather hear about experiences rather than have them reduced to statistical power. In contrast to quantitative research where process and meaning are structured and measured, qualitative research describes process and meaning in terms of intensity, patterning and frequency (Denzin & Lincoln, 2000).

The use of qualitative descriptive research is common in nursing and midwifery research (Annells, 2007; Fenwick, Hauck, & Downie, 2005; Gilmor & Huntington, 2005; Sheehan, Schmeid, & Cooke, 2003). Qualitative research allows for the development of new perspectives on known areas or ideas necessary for meeting health needs (LoBiondo-Woods & Haber, 2006). LoBiondo-Woods and Haber add that qualitative research also contributes to guiding practice, testing instruments and building on existing theory. Answers obtained through qualitative inquiry help provide better understanding about certain phenomena, populations or clinical situations and is especially good when little is known about a particular phenomena (Sandelowski, 2004).

Qualitative research is directed at the discovery of meaning and involves the use of language, concepts and words to represent research evidence (Fain, 2004). The participant is regarded as possessing the knowledge with research being carried out in its natural settings in

an attempt to make sense of and interpret phenomena in terms of the meanings people bring. In this naturalistic environment there is no pre-selection or manipulation of variables to the study (Sandelowski, 2000).

Philosophies underpinning qualitative research assume that knowledge is socially constructed and that multiple realities exist (Streubert & Carpenter, 1995). Fain (2004) describes qualitative research as process oriented with a focus on participants' perspectives and description of experience in a social context. In qualitative research, the focus is on the researcher and participant relationships, the description of social experience and emerging meanings, and the environmental factors that may shape inquiry. In this study, elucidating the experiences of nurse supervisors aims to provide the individual realities and common perspectives as experienced by them.

#### **4.4 Qualitative descriptive research**

In this study a qualitative descriptive design was used to explore and describe the experiences of mental health and addictions nurses who provide clinical supervision. Descriptive research seeks to answer the *what, who and where* questions about an event, experience or phenomenon of interest (Sandelowski, 2000).

Sandelowski (2000) recommends that qualitative descriptive approach is suited to examine questions within their own contexts. She further states that although qualitative descriptions are atypically diverse, sampling, data collection and analysis methods can be used in a variety of combinations in order to answer the research question. The design is flexible and allows researchers to use combinations of sampling, data collection and analysis and allows the researcher to continuously respond to new knowledge as it comes up during the course of the study (Polit & Beck, 2006). The nature of the human and creative activities of mental health nursing calls for its understanding from many perspectives (Chambers, 1998).

A qualitative descriptive design is useful to discover individual's knowledge and to understand the rich descriptions derived from social experiences from the participant's perspective (Fain, 2004). This design seeks to describe human experiences within their contexts, in everyday language and is a suitable alternative where traditional quantitative

research paradigms and positivist theoretical or philosophical frameworks are not specified (Sandelowski, 2000). Quantitative methods tend to reduce experience to statistical measures and do not provide researchers with the flexibility to use combinations of sampling, data collection and analysis that qualitative methods do.

This qualitative descriptive approach is suitable where time and resources are scarce (Neergaard, Olesen, Andersen, & Sondergaard, 2009). As a sole researcher working within a specified and limited time frame within which to complete the study qualitative descriptive approach was suitable for the study. Academic supervisors were involved to provide support and to critique the research process throughout the study.

The goal of qualitative descriptive research is to describe events from the real life data obtained from participants in their own language. The information obtained is spontaneous and allows for inquiry to happen in its naturalistic state (Mason, 2002). Qualitative description allows for generation of straight forward descriptions and not complex interpretations (Streubert & Carpenter, 1995). The researcher stays close to the descriptions provided by participants and to their data (Morse & Field, 1996; Sandelowski, 2000).

Qualitative descriptive designs have been a useful approach to study mental health nursing in New Zealand. Fourie, McDonald, Connor and Barlett (2005), for example conducted a qualitative descriptive study to ascertain the perceived roles of registered psychiatric nurses in in-patient settings. In another study a qualitative descriptive methodology was used to explore attitudes, knowledge and skills mental health clients' views as important in the delivery of care by mental health nurses (Rydon, 2005). Mental health nurses bring a holistic approach to the understanding of the human experience (Halloway & Wheeler, 1996; Minichiello, Sullivan, Greenwood, & Axford, 2004). The human interactions in nursing practice are a core focus of clinical supervision. Because of its concern with human experiences, qualitative description was chosen as the best methodology to explore the research question and illuminate participants' experiences in this study.

#### **4.5 Sampling in qualitative research**

In qualitative research sampling is “ the process of choosing suitable units of interest so that the focus of the study is can be adequately researched”(Schneider et al., 2007 , p. 123).

A purposive sampling technique was used in this study. Schneider et al. (2007) describe purposive sampling as occurring when the researcher selects people with the required status, experience or knowledge to provide the information to answer the research question. Purposive sampling is often used in qualitative research because the quality of information obtained is much more important than numbers of participants (Patton, 2002). Purposive sampling takes into account the setting, events, incidents and experiences, not just the people (Miles & Huberman, 1994; Strauss & Corbin, 1990). According to (Morse, 1991; Patton, 2002) participant selection should be adaptable to the context of the study in question. Purposive sampling provides information rich cases for the study in order to gain inside information from the people who are intimately involved. Patton (2002), states that purposefully selected samples focus more deeply on the phenomenon. Information rich cases are those from which a great deal can be learnt about issues that are important to the research purpose. According to Sandelowski (1995) “Qualitative researchers value the deep understanding permitted by information-rich cases, events, incidents and experiences are typically the objects of purposeful sampling” (p. 180).

#### **4.6 Validity, trustworthiness and rigour in qualitative research**

Validity is concerned with the quality criteria with which research is judged. In qualitative research, validity is ensured by the rigor that is applied by the researchers as well as by the readers of the research reports (Rolfe, 2006). Furthermore, validity is achieved through the consensus on individual studies rather than by the application of predetermined criteria.

Validity in qualitative research requires the researcher to show that the phenomena under study is reflected accurately (Polit & Beck, 2006; Streubert & Carpenter, 1995). There is no need to be concerned with the ‘truth or falsity’ of an observation or event but rather with trustworthiness (Sandelowski, 1993; Trochim, 2006). Whittemore, Chase and Mandle (2001) urge qualitative researchers to be flexible and creative in their application of research while remaining cognisant of the need to balance this with reasonable claims, evidence and sound methods, otherwise they run the risk of producing results that are not reflective of the phenomenon of concern.

## **4.7 Criteria for judging qualitative research**

The criteria for judging qualitative research has been proposed under the umbrella of trustworthiness with headings of credibility, transferability, dependability, confirmability and reflexivity (Graneheim & Lundman, 2004; Lincoln & Guba, 1985; Nightingale & Cromby, 1999). These have been described below and the steps taken by the researcher to establish rigour have been highlighted in the research methods section of this chapter.

### ***4.7.1 Credibility***

Lincoln and Guba (1985) suggest that in qualitative research, credibility is the overriding goal. Credibility refers to the notion that the results of research need to reflect the experiences and meanings of participants in a way that is believable (Lincoln & Guba, 1985; Sandelwoski, 1993). Credibility involves the truthfulness of findings from the perspectives of research participants and others involved in the study. In this study, the purpose was to describe the experiences of mental health and addictions nurses who provide clinical supervision from their perspective. Schneider, Whitehead, Elliott, Lobiondo-Wood and Haber (2007) suggest audit trails, member checking and peer analysis checking as some of the criteria that could be used as evidence for credibility.

### ***4.7.2 Transferability***

Transferability or ‘fittingness’ is the extent to which the results can be transferred to other settings or contexts (Polit & Hungler, 1999; Schneider et al., 2007). This involves research to being described with enough detail to enable other people to evaluate its implications for their own practice, research and theory development (Stenbacka, 2001). Due to the subjective nature of qualitative research, transferability of findings is not always feasible. Consequently, acceptance or rejection of research findings is dependent on subjective criteria, that is to say the reader of the report makes the judgement as to its trustworthiness (Rolfe, 2006).

### ***4.7.3 Dependability***

Dependability refers to whether the results of a study can be replicated if the study was repeated by another researcher. With qualitative studies, it could be argued that it is not possible to describe and evaluate the same phenomena twice and expect to get the same results. The view that knowledge is socially constructed and may change supports this argument (Crotty, 1996). The criterion of dependability thus places emphasis on the researcher to be mindful of the changes that can occur in the phenomenon under study and to



be able to describe the effect of those changes on the study. Thoroughness and logical congruence should be established between the research question, the method, and findings and between data collection and analysis. Furthermore congruence between the study and any previous studies should be apparent. Lastly, Whittemore, Chase and Mandle (2001) assert that congruence should be evident between the findings and practice. The reader must then judge the accuracy and adequacy of the research information presented to them.

#### ***4.7.4 Confirmability***

Confirmability is the degree to which the results can be corroborated by others using similar data and context. It is concerned with presentation of the combination of credibility, dependability and transferability standards (Schneider et al., 2007). Confirmability can be achieved by conducting data audits to examine the data collection and analysis procedures and then reporting on potential bias (Trochim, 2006).

#### ***4.7.5 Reflexivity***

Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgement of the impossibility of remaining outside of one's subject matter while conducting research (Nightingale & Cromby, 1999). Reflexivity also requires an awareness that realities are socially constructed and that there are subtle differences in the voice of participants that require the ability to speak for them in an authentic fashion (Lincoln & Denzin, 1994). In addition, reflexivity allows both the researcher and participants to gain new knowledge and understanding about themselves from the research process rather than it being just used as 'self-check' tool for bias during research (McCabe & Holmes, 2009).

### **4.8 Limitations of qualitative descriptive design**

Qualitative description is not without its limitations. According to Milne and Oberle (2005) criticism of qualitative descriptive design is often around the absence of any theoretical base. The absence of a single universally understood viewpoint about qualitative studies mean that studies can only be evaluated individually based on the researcher's report (Sandelwoski and Barroso 2000, as cited in Caelli, Ray, & Mill, 2003). The authors suggest the need for researchers to provide greater detail about the approach and methods used in order to facilitate appropriate evaluation of each research study.

While Sandelowski (2000) argues that qualitative descriptions have low-inference interpretation, there are some doubts as to whether the straight descriptions of qualitative description can be totally free of interpretation. Researchers may assume a taken for granted view of the participants' world. The outcome of descriptions can therefore be influenced by the researcher's perceptions, inclinations, sensitivities and sensibilities (Giorgi, 1992; Morse, Barrett, Mayan, Olson, & Spiers, 2002).

## **4.9 Research methods**

This section describes the application of the research method. The chosen methods of data collection; semi-structured interviews and focus group discussions and data analysis are described. The study setting, sampling, recruitment procedures and ethical considerations are outlined. The criteria applied to ensure rigour and validity of the research is also described.

### ***4.9.1 Study setting***

The study was carried out within the Mental Health and Addictions service of a New Zealand DHB. The DHB employs nurses in a variety of settings and geographical locations within the service. These include alcohol and drug, child and adolescent, early intervention maternal mental health, rural services, urban community mental health, consult liaison, adult and older persons inpatient wards, forensic inpatient wards and community forensic services. The focus of the services is to provide assessments, treatment or/and care of people with mental health and addiction problems.

### ***4.9.2 Study sample***

The participants were a purposive sample of mental health nurses who currently provide clinical supervision within the DHB. The DHB defines a clinical supervisor as "a health professional registered with the Nursing Council of New Zealand (2007) and has approval for this role from the person's discipline specific Professional Advisor, Clinical Nurse Director or Maori Mental Health Service Director". According to the Clinical Nurse Director of the service in which this study took place, a mental health nurse clinical supervisor is one who has received appropriate training either in New Zealand or overseas and is able to provide individual or group supervision.

There is agreement among qualitative researchers that sample size is relative, that is, participants are selected to suit the needs of the study (Coyne, 1997; Sandelwoski, 1995). An adequate sample size is one that fully answers the research question. Adequate sampling is summed up as “...one that permits by virtue of not being too large.... the deep, case-oriented analysis that is a hallmark of all qualitative inquiry, and that results in .... by virtue of not being too small.... a new and richly textured understanding of experience” (Sandelwoski, 1995, p. 183).

Fifteen participants took part in the individual interviews. Between 15 and 20 participants have been suggested as a sufficient number for obtaining rich descriptions required in qualitative descriptive research (Creswell, 1998). The variability in gender, age, workplaces and nursing and clinical supervision experiences of the participants provided variation within this sample. This is consistent with the assertion that sampling for demographic homogeneity is a suitable method when working with limited resources without compromising the credibility of the analysis and findings (Sandelwoski, 1995). As a sole researcher working within a limited time frame, this sample was considered practicable and sufficient to provide the depth and quantity of data necessary to meet the study objectives.

Inclusion criteria included both male and female nurses engaged in clinical supervision for two years or more and supervising one or more supervisees. Nurses who worked in my team, my own clinical supervisor and my own supervisees were excluded from the sample to avoid power and relational dynamics that could alter responses during the data collection and analysis. The study intended to explore experiences of mental health nurses who provide clinical supervision within a New Zealand DHB, therefore nurses involved in external clinical supervision were excluded from the study. The reason for choosing the particular purposive sample arose from the recognition that the participants would provide rich descriptions that were more likely to provide better insight and understanding of their experiences. Purposive sampling brings about improved understanding of particular issues and events rather than generalized results.

#### ***4.9.3 Recruitment***

A list of all practising supervisors ( $n=48$ ) was obtained with permission from the Clinical Nurse Director who has the overall responsibility for clinical supervision for nurses in the DHB. Three supervisors were immediately excluded from the study. The first was the

researcher's line manager. The second had left the service and the third supervisor was the researcher. Letters were sent to the remaining 45 clinical supervisors via the internal mail service inviting them to participate in the study (Appendix A). Information sheets and consent forms were attached (Appendices B and C). The participants were invited to contact the researcher by phone or e-mail to ask any questions and to get any clarification about the study. Participants who met the criteria and were willing to participate were asked to sign and return the consent form to the researcher.

Within two weeks of sending out the invitations 17 clinical supervisors had responded. Fourteen met the inclusion criteria and returned their signed consent forms. One supervisor declined to participate, citing pressure of work. The other supervisor was not providing any supervision at the time of the study and the third supervisor was not a mental health nurse so both these did not meet the inclusion criteria. After the third week invitation letters were resent to supervisors who had not responded to the first letters. Only one more supervisor responded and agreed to participate in the study, bringing the total number of participants to 15. Once a signed consent form was received, the researcher contacted the participants and arranged suitable venues and times for the interviews. Fourteen participants agreed to take part in both individual interviews and focus groups. Only one participant declined to participate in focus group discussions because of problems with distance to the proposed meeting venue. The table below illustrates participants' demographic details:

**Table 1** *Description of Participants*

Characteristics	N
Participants	15
Male	5
Female	10
Age range (years)	36-60
Experience in nursing (years)	13-35
Experience as clinical supervisor (years)	4-20
Receiving supervision	13
Not receiving supervision	2

#### ***4.9.4 Collection of data***

Data collection in qualitative research is associated with collecting information directly or indirectly from an identified and selected sample population. Various methods of collecting data can be used on their own or in combination with other methods (Schneider et al., 2007). Sandelowski (2000) stated that qualitative data collection aims to discover “the who, what and where of events and experiences...” (p. 338). The researchers seek to explore the thoughts, feelings, experiences, meaning of experience, interactions, responses, actions and individual and group processes within their social and cultural settings (Schneider et al., 2007).

In this study the interview method was chosen to collect data. Two processes, semi-structured face to face individual interviews and focus group discussions were proposed.

##### *Face to face semi-structured interviews*

Face to face interviews allow for an interactive relationship and facilitate progressive development of further areas of enquiry (Halloway & Wheeler, 1996). The individual interview method also offer both the researcher and the participant a non-threatening and supportive environment (Whitehead & Annells, 2007). Due to the sensitive nature of issues that come up during clinical supervision one to one interactions are best suited for safe information gathering.

A semi-structured interview guide was piloted with a colleague and with another independent person. This enabled the researcher to practise and polish interviewing techniques and to identify and rectify any inconsistencies (Roberts & Taylor, 2002). The interview transcript was double-checked with the academic supervisor to test its reliability and to reduce researcher bias. It was important to demonstrate a good command of interviewing skills so as to facilitate the exploration of participants’ experiences effectively (Polit & Hungler, 1999). The feedback comments from the supervisor were then used to make some adjustments to the interview guide.

Semi-structured, open ended, face to face individual interviews were conducted in a private place of the participant’s choice. Each interview lasted between 30 and 90 minutes. Interview schedules were arranged and conducted to suit normal work routine so as not to encroach on the participants’ private time. The researcher used an interview guide to ask

open ended questions (Appendix D). The interview guide was used to keep interviews focused, to reflect the study objectives and to ensure that every participant got an opportunity to respond to all questions (Polit & Hungler, 1999). Probing questions were used to further explore the responses and collection of information continued until all fifteen participants had been interviewed (Lincoln & Guba, 1985). In addition participants were asked to provide demographic information about their clinical settings, age, gender, length of time in the nursing service, when and where supervision training took place and length of time in clinical supervision.

All the interviews were audio taped and transcribed verbatim with the participants' consent. A professional transcriber who had signed a confidentiality agreement was engaged to transcribe the interviews (Appendix E). The transcriber surrendered all equipment and data at the end of data collection. It was kept in a secure place and accessed only by the research team that included the researcher and academic supervisors. All the information including notes, tapes and consent forms will be kept in a locked place for seven years after completion of the study.

#### *Focus groups*

At the planning stage of the study the rationale to conduct two focus group discussions following the analysis of the data collected in individual interviews was that focus group discussions would enable further exploration and clarification of any outstanding issues in a collective setting. This method would have allowed participants to discuss and explain amongst each other their experiences of clinical supervision thereby adding richness to the previously collected data (Morgan, 1996). In a triangulation strategy, focus group discussions would have added credibility to the study by allowing a more comprehensive and varied exploration of the phenomenon (Johnson & Waterfield, 2004). However, two issues arose during data collection. Firstly during the individual interviews it was noted that some participants were in supervisory relationships with each other. This raised an ethical concern around confidentiality and openness during discussions because the possibility that participants who were in supervisory relationships might be in the same group was very high. Secondly there was a large response to invitations, which resulted in fifteen individual interviews being conducted. The interviews elucidated such a large volume of information that it was felt that no new information would be yielded by conducting focus group discussion with the same participants. It was therefore felt that the enormity of the data would

compromise its analysis (Gibbs, 1997). After some discussion with the supervisor, it was decided that focus group discussions would be called off. Participants were informed of this.

#### ***4.9.5 Applying reflexivity***

As a researcher with subjective knowledge and experience of the research topic and familiarity with participants, I brought my own assumptions but I took measures to ensure that my assumptions did not get in the way. Ongoing reflective processes throughout the study were essential to reduce bias and threats to validity (Denzin & Lincoln, 2000). I needed to identify my possible biases and to develop strategies for dealing with them. Before and during the study I undertook a conscious awareness of my own understanding of clinical supervision and of being a supervisor. Being a part of the world which I was investigating required me to acknowledge the possible influence that I might have on the participants and on the research outcomes (Carolan, 2003). I ensured that focus of their experience was maintained. Another strategy was for me to divorce myself from potential conflict by excluding my own clinical supervisor and team mates from the study. Another strategy involved regular discussions with my academic supervisor throughout the study to enable possible beliefs, perceptions and ideas to be constantly checked, challenged and critiqued. The discussions ensured that findings were clarified and confirmed allowing for greater breadth and depth to the study (Denzin & Lincoln, 1994). Member checking with participants during and after the interviews allowed clarification and correction of any misunderstandings (Patton, 2002). Audio taping, transcribing and thematic analysis ensured that the participants' voice was heard.

#### **4.10 Ethical considerations**

Ethical considerations in research include sensitivity to the dynamics of human, cultural, and social contexts. To uphold human dignity and respect for participants researchers need to ensure that research serves the purpose of the community in which it was carried out rather than to simply satisfy the community of knowledge producers and policymakers such as researchers and their funders (Lincoln, 1995). Qualitative research requires that the integrity of the process be upheld throughout the study. In this study, ethical issues were respect for participants, informed consent, privacy and confidentiality, minimisation of harm, justice, cultural and social responsibility and respect for Tikanga Maori.

#### ***4.10.1 Respect for participants***

The fact that most potential participants were known to the researcher because of being in the same profession and working in the same organisation might have created awkwardness with regards to their decision to participate or not to participate in the study. Potential participants who did not respond to the study invitation and those who declined to participate or to respond to certain questions were assured that their decisions would not affect their future relationship with the researcher. Data collection was undertaken at a time and place that was convenient for the participant. Due to work pressure and sudden changes in workloads some participants cancelled their appointments. In such cases appointments were rescheduled to suit the participants' schedules. In most instances, the researcher travelled to meet with the participant at an agreed venue. Where participants incurred parking costs, these were reimbursed. Efforts were made to respect individual responses and opinions about their experiences without judgement.

#### ***4.10.2 Informed consent***

Once permission to undertake the research was obtained from The University of Auckland Human Participants Ethics Committee (Appendix F) and The District Health Board Ethics Committees, letters of invitations were sent out to potential participants. Information sheets stating the aim of the study, the potential benefits, risks, outcomes, why participants had been chosen, and method of data collection to be employed, duration of study and time commitments were attached (Appendix B).

Attached to the information sheet was a consent form that participants were asked to sign and return to the researcher (Appendix C). They were also given the opportunity to ask questions about the study before and during the study by contacting the researcher or the researcher's academic supervisor. Confidentiality, provision of support and anonymity was explained and assured.

Those intending to participate in individual interviews were informed of their right to withdraw their consent and information at any time before the commencement of data analysis without giving a reason. The researcher assured confidentiality of their identities and all information collected during individual interviews but gave no absolute guarantee of confidentiality of information shared during focus groups. Potential participants were asked to respect each other's confidences during focus group discussions.



Participants were informed that their interviews and transcripts would be kept in a secure place and that at completion of the study participants would be given back a copy of their interview at their request. Potential participants were informed that the information they provided would be analysed for themes. A summary report of the findings would be given to them at their request and study results may be used by other researchers in future and may also be presented at mental health nurses' forums.

#### ***4.10.3 Privacy and confidentiality***

Attempts to address the rights to privacy and confidentiality of the individuals and the organization were maintained throughout the study. While every effort was taken to protect the identity of the organization, the potential risk of its location being identified once the thesis is published was acknowledged. Anonymity of participants was maintained by allocating them pseudonyms. Efforts were taken to ensure that no identifying information appears on the transcripts or any other related documentation. Participant information was used for agreed upon purposes, that is, the information would be analysed for themes and some quotes from interviews may be published to reflect participant views in the final report. The responsibility of confidentiality issues in focus group discussions was made collectively through an agreement that all participants involved would not discuss the content of discussions outside of the group.

#### **4.11 Benefits/risks of taking part in the study**

Participants were informed that although there are no direct benefit to participants from taking part in the study it is anticipated that the value of the study will assist mental health and addictions nurses to reflect on and inform their practice around clinical supervision and that the information gathered will assist in the provision of quality interventions and enhance the outcomes for service users.

#### **4.12 Minimization of harm**

No risks were anticipated for participating in the study. However, some discussions in clinical supervision can evoke personal or professional emotions that often require appropriate interventions to assist the nurses. Participants were assured that should any

discomfort arise from the discussions, with their permission the participants would be referred to the Employee Assistance Programme for support. Assurance of confidentiality and anonymity by the researcher may have helped to reduce any anxiety. The researcher's relationship with participants in that most of them were known to her and to each other might have strengthened trust and reduced some anxiety too.

#### **4.13 Treaty of Waitangi**

The Treaty's principles of partnership, protection and participation and self determination were considered in the study. These principles require a commitment by health care providers to be responsive the health needs of Maori. A review of current approaches to professional supervision internationally and in the New Zealand mental health and addictions sector reiterates the need to understand the cultural needs of Maori and to be able to provide appropriate interventions (McKenna et al., 2008). There is a statistical over- representation of Maori as consumers in mental health services with Maori having the poorest health of any ethnic group in the country. Maori are twice more likely to experience mental illness than non-Maori (Ministry of Health, 2002a).

Before commencing the study consultation and advice was sought from Te Puna Oranga (Maori Health Service) and Kaumatua Kaunihera (District Health Board Cultural Research Committee) and they supported the project. A summary report of the research will be submitted to the committee at the completion of the project. Advice was also sought from the University's department of Maori Health.

During the study, all participants were given opportunities to make suggestions about how clinical supervision should be implemented and supported. It was anticipated that this inclusion would allow a level of participation.

Although the study did not specifically target Maori, it was anticipated that there would be some Maori participants from the 48 available clinical supervisors. Inclusion of Maori in the study would be beneficial to the clients and also facilitate active participation and partnership in planning and in organisational decision making of supervision which is central to reducing inequalities in health. Supervisors who are competent would help other nurses to be effective in providing quality and safe care. While 2 of the 15 participants in the

study identified as Maori they both worked in the mainstream service and did not provide Kaupapa Maori supervision.

#### **4.14 Ethical approval**

The study involved human participants employed by a district health board. Research that involves people has potential ethical implications that require consideration and addressing. Before this study was carried out ethical approval was requested and granted by The University of Auckland Human Participants Ethics Committee (Appendix F). Support was also given by the Office of the Tumuaki at the Faculty of Medical and Health Sciences to support the ethics approval process (Appendix G). Permission and support to conduct the study with mental health nurses was sought and obtained from the DHB management including the Office of Kaumatua Kaunihera (Maori Mental Health Service). Copies of the ethics application and approval letter from University of Auckland Human Participants Ethics Committee were sent to Clinical Nurse Director and to the DHB Ethics Committee. To acknowledge Maori culture and to address health inequalities and the principles of the Treaty of Waitangi, the Health Equity Assessment Tool [HEAT] was completed with consultation of Te Puna Oranga, the District Health Board Cultural Research Committee (Ministry of Health, 2004). Final consent was sought from individual participants.

#### **4.15 Data analysis**

Qualitative data analysis is defined as a process of working with data, organizing it, breaking it into pieces, synthesizing it, identifying patterns, discovering important information, discovering what is to be learned and deciding what should be shared (Bogdan & Biklen, 1982). The analysis involves step by step procedures to place raw data into logical, meaningful categories, examine them and communicate the outcomes to others (Patton, 2002). Unlike quantitative analysis that seeks to identify statistical representations, qualitative research seeks to preserve textual data and to present it as explanations and with the use of participant voice (Pope, Ziebland, & Mays, 2000). Data analysis organises the data into meaningful, individualised frameworks that describe the phenomenon under study (Burns & Grove, 2005). The analysis strategy selected for the descriptive nature of this study is thematic analysis (Boyatzis, 1998). The approach involves the development of codes from

raw data inductively and facilitates access to new discoveries and insights and enhances clarity of findings. The inductive approach is recommended for studies that are concerned with understanding the meanings people put to their lives (Cutcliffe & Goward, 2000). The approach is also indicated when knowledge about a phenomenon is not enough or is fragmented (Elo & Kyngas, 2008).

The process of data analysis began with transcribing the audio taped data. Due to the large volume of data collected, a qualified transcriber was engaged to assist with transcription of some of the interviews. Transcription assisted the researcher to immerse herself in the data and to begin to make sense of what the participants were saying. All transcriptions were read and re-read while the researcher listened to the audio tape to ensure the transcripts were accurate. On several occasions the researcher sought clarification from participants on the use of certain terminology to ensure that she understood what was being said.

In the beginning the researcher attempted to create categories by using the research questions on the interview guide as headings. The relevant sections identified from the transcripts were then cut and pasted onto the relevant research question until all the transcripts were analysed. Any information that could not be fitted into existing headings was put aside and was later fitted into three additional headings. This categorical method proved to have flaws in that there were large chunks of information per category with some of it overlapping into other categories. There was a danger of prescribing the categories too quickly and losing some salient points.

The researcher then adopted an approach of line by line reading, selecting and highlighting text to identify words, phrases and events that appeared to be similar (Van Manen, 1990). Similar words and phrases were grouped together into named themes. Tentative names of themes were kept as close as possible to the words in the text to keep the researcher in context with the meaning of the data. An audit trail to link data to the participants was also devised using letters, colours and numbers. Three transcripts were first analysed with each one yielding between 20 and 30 themes. The researcher then discussed these findings with two academic supervisors to obtain feedback and to refine the themes. This dialogue was important in order to determine uniformity in the way the data was labelled and sorted (Graneheim & Lundman, 2004). The discussions also accounted for the researcher's 'decision trail' a factor that is important to ensure credibility of the study

(Lincoln & Guba, 1985). Further refinement followed with the researcher collapsing the data from the three transcripts into a total of four themes and nine sub themes that best described the nurses' experiences of providing clinical supervision. The remaining 12 transcripts were each read and highlighted using the same thematic framework. Data that was consistent with existing themes was identified and placed within the appropriate themes and subthemes. However, not all data fitted within the framework. Therefore as new themes were identified, the framework was expanded and adjusted. At times, this process required a re-examination of the existing themes and revisiting of previously analysed interviews. The identified themes, together with quotations that convey the meanings were then reported in the findings.

#### **4.16 Conclusion**

This chapter has described qualitative descriptive research design and provided a rationale for why it was the most appropriate method to explore the experiences of mental health and addictions nurses who provide clinical supervision in a DHB. Ethical issues and ethical approval processes have been described. Data collection and analysis methods, including the steps taken to maintain rigour have been outlined. Findings of the study are described in the next chapter.

## CHAPTER FIVE: FINDINGS

### 5.1 Introduction

Chapter four described qualitative descriptive research, the objectives of this study and the research methods used. This chapter presents the findings of this study. The findings are presented according to the themes that emerged from the transcripts of individual interviews. Four main themes and multiple sub themes emerged from the analysis. The themes and their subthemes are illustrated in Table 2 below and are then described.

**Table 2** *Main themes and subthemes*

<i>Main theme</i>	<i>Subtheme</i>
Acquiring and maintaining the ‘nuts and bolts’ of clinical supervision	<ol style="list-style-type: none"><li>1. Stepping up to become a supervisor</li><li>2. Training in the theory and practice of clinical supervision</li><li>3. Up skilling as a supervisor</li><li>4. Receiving supervision</li></ol>
Practising flexibly within supervision frameworks	<ol style="list-style-type: none"><li>1. Laying the foundations of the relationship</li><li>2. Sharing responsibilities</li><li>3. Focusing on clinical issues in supervision</li><li>4. Adopting a flexible approach</li></ol>
Integrating clinical supervision and nursing practice	<ol style="list-style-type: none"><li>1. Building on personal and professional attributes and skills</li><li>2. Developing own nursing practice through providing supervision</li><li>3. Applying tools of clinical supervision to practice</li></ol>
Working within organisational frameworks	<ol style="list-style-type: none"><li>1. Responding to ambiguous policies</li><li>2. Working within organisational resource constraints</li><li>3. Benefitting from organisational processes and supports</li></ol>

The main themes are; acquiring and maintaining the ‘nuts and bolts’ of clinical supervision; practising flexibly within supervision frameworks; integrating clinical supervision with nursing practice; and working within organisational frameworks. Quotations from the interviews have been used to illustrate the themes. In some instances the quotations have been slightly altered to protect the identity of the participants. Care has been taken to ensure that the changes have not altered the meaning of the statements.

## **5.2 Acquiring and maintaining the ‘nuts and bolts’ of clinical supervision**

All fifteen participants were asked to describe their initial mental health or general nursing training. This background information was important in providing a platform that led to the exploration of participants’ subsequent involvement and experiences of giving clinical supervision.

Becoming a recognised and competent supervisor was central to this theme. All participants considered that training in the theory and practice of clinical supervision was fundamental to their own development and to the successful implementation of clinical supervision. Education provided the nurses with the means to have a clear understanding of clinical supervision and an opportunity to provide it as part of meeting the wider objectives of the organization. This theme includes four subthemes; stepping up to become a supervisor, training in the theory and practice of clinical supervision, upskilling, and obtaining on-going support.

### ***5.2.1 Stepping up to become a supervisor***

Becoming a supervisor involved a conscious decision by nurses to ‘step up’ to a formal role beyond that of clinician. The motivation to step up to the role was influenced by internal and external factors. Although the reasons given for taking up clinical supervision varied amongst the participants, personal commitment, organizational and political imperatives and supporting professional growth for themselves and for colleagues were stated as the main reasons for taking on supervision training.

#### ***Personal commitment***

All participants mentioned that the main drive was their personal commitment to supervision training and to provide support to other health professionals and to the organisation:

*I wanted to be a supervisor ...I've always been committed to the ideals of supervision and the practice of supervision. So I guess to that extent, I'm quite committed to the idea of supervision (Participant D).*

Another participant's commitment to clinical supervision was driven by a combination of curiosity and the need to develop others:

*It's really interesting to hear about how people do things and why they do what they do. I guess it pays to be nosy...I love it because I'm really genuinely interested in how people work. And how they deal with different things because you know, that's just probably why I'm a mental health nurse...I like to support nurses to be mental health nurses (Participant N).*

#### *Fulfilling organizational and political needs*

The call by the organization to formalise clinical supervision was stated as the major drive to move away from what participants referred to as 'corridor' or 'ad hoc' conversations to doing formal structured sessions. Participants noted the move towards structured supervision and responded by electing to equip themselves with skills and knowledge that enabled them to provide clinical supervision in formal settings. One participant highlighted their former experience of supervision:

*Supervision mostly took place in conversations in the corridor kind of thing (Participant A).*

Another noted the shift towards structured supervision:

*...Clinical supervision did occur but it wasn't called clinical supervision and it was much more ad hoc, so it wasn't structured ...then around about 4 or 5 years ago, there was an opportunity for people to be trained (Participant D).*

Another participant reflected on the rationale to shift from informal supervision to practising clinical supervision in a structured way:

*I think informally I was probably providing supervision to students anyway...it was just wanting that experience and getting those skills and knowing what I was actually doing rather than you know just waffling through things... I just wanted a bit of structure about what I was doing (Participant B).*

For other participants, pressure from the organization was the reason for taking up clinical supervision:



*It became a bit of an imperative here which was probably about 5 years ago...there was a lot of people talking about you must do it and this was coming from management and senior staff and the profession (Participant I).*

Five participants stated that they undertook clinical supervision because their roles [senior nurses, nurse educators, clinical nurse specialists] within the organization required them to do so:

*...one of the prerequisites [for my role] was that you were a clinical supervisor... I had heard good things about it... so having the opportunity to do the training and learn more about it... that was great, so from there I could see its benefit... I suppose curiosity but it was part of my prerequisite [educator] (Participant J).*

Another senior nurse stated:

*I first undertook some training in clinical supervision because an expectation of the role [as a clinical nurse specialist] was to provide clinical supervision (Participant L).*

One participant who commenced supervision overseas described political and organisational directives within nursing as the main drives behind them becoming a clinical supervisor. The participant stated that:

*You can call it a political push... at the time for clinical supervision. So pretty much anyone that had been practising for two plus years they were offered and encouraged to undertake training to provide clinical supervision. And as a result everyone was encouraged to have ongoing clinical supervision (Participant I).*

#### *Giving back to the profession*

Two participants used the opportunity of their own positive nursing and supervision experiences to give back and to support other health professionals:

*I always wanted to give something back because I had had such a good experience (Participant K) [as a supervisee].*

The second participant commented that:

*I like to support nurses to be mental health nurses because for me it's been a really rewarding kind of a job and I just hope to share some of my enthusiasm for the job and hope to make things a bit easier for people (Participant N).*

For another participant 'stepping up' involved them building on existing skills:

*...I've always, always had that sort of interest in teaching, educating, motivating, inspiring people, so they all sort of sit together [with clinical supervision]...I also like to do learning (Participant C).*

Another participant added that their teaching background enabled them to extend it to clinical supervision:

*...had an interest in developing others and I think that comes from being a lecturer... where you are developing people, you are asking reflective questions (Participant O).*

Whilst clinical supervision was initiated and driven by the organisations, the final decisions to take up the role of clinical supervisor were with the individuals who chose to accept to do it. The nurses revealed that it was their enthusiasm, personal and professional commitment that enabled them to want to provide clinical supervision.

### **5.2.2 Training in the theory and practice of clinical supervision**

Training in the theory and practice of clinical supervision was essential to the practice of supervision in mental health. Participants had all received some form of training in clinical supervision.

The participants stated that the knowledge and skills they learnt in their supervision training assisted them to practise as competent supervisors:

*I needed some kind of nuts and bolts to hang some supervision so that I could practise as supervisor and feel safe to do that (Participant D).*

Another participant described the extra benefits he got from training to be a supervisor:

*[The training]... jacked up my teaching skills it's jacked up my listening skills with people and I think it improved my level of observation as well (Participant K).*

There were differences between the training. The supervision training programmes varied in content and process depending on whether the nurses did their training overseas or locally.

### *Supervision training courses*

Before 2005, local training courses were sponsored by the District Health Board and the training was provided by an external agency. Ten nurses who participated in the local supervision training stated that the courses were short and intensive. The course lengths varied from two days to two week workshops. Some of the training involved some course work in between the blocks. One participant described the structure of the course she attended:

*It [training] was 10 days in total, broken up into blocks of 5 days (Participant J).*

Another participant expounded on the same training with the following comment:

*So it was a very short course. It was only a 14 day module course... the training at that time it was run by the technical institution in Wellington and I think they had historically provided quite a bit of nursing training for supervision over the years to the [name omitted] and I probably was part of the last course. So it was 14 days. It was 2 lots of a week and it really was just a certificate level course (Participant D).*

When asked to talk more about the course, one participant said the following:

*...quite intense training, a lot of work really supervising each other and going through experiences that we had had ourselves in the workplace... and it was some assignments and we also had to do some supervision on colleagues... We had to sit a sort of a test as well and had to pass (Participant M).*

All the ten participants mentioned that the training content focussed on a particular (TAPES) model of supervision. They described that they learnt to use the TAPES model (O'Donoghue, 1998) The acronym TAPES enumerates five areas (Theory, Assessment and intervention planning, Parallel Processes, Ethical issues and professional practice, and Strategies and intervention techniques). They used the model to identify clinical issues and to address these issues as they arose in clinical supervision. The following excerpts from two of the participants indicated that the focus of the training was on a particular model of supervision:

*We went through all of the theory and predominantly focused on TAPES. I can't recall if we did any other models. If we did it wasn't that we actually learnt them. It was more around perhaps talking about it (Participant J).*

*...there was an opportunity for people to be trained in what was then the TAPES model ...so I did that TAPES course and I've been practising since then really (Participant D).*

In the last four to five years, clinical supervision training provided by the organization shifted to a yearlong part time course that was now being run by a different institution. This was attributed to the move by the DHB to provide more generic training that would expose clinical supervisors to a wider range of supervision concepts and models. One participant in the study attended the year long course that was offered by the DHB:

*I think that is one thing the DHB provides training of, and there are various sorts of ways of being recognised and one is a cert, post grad certificate I think I was one of the first to go through the [place omitted] clinical supervision which was a year`s ... it was a post grad certificate in professional supervision (Participant O).*

Three participants received clinical supervision training in the United Kingdom before 2005. They attended longer part time courses and felt that the courses that they attended were more comprehensive than the ones offered in New Zealand at the time. One participant elaborated on the course she attended:

*It was a one year course, so I went to Tech once a week. We had assignments to do and we had teaching sessions to do and a practical assessment where you were assessed actually doing supervision and we did that over a year ...and they approved it and ... you could then do supervision for students and for qualified staff (Participant B).*

All the three participants who received training in the United Kingdom explained that they had learnt various supervision models in their training. The models and their application are described in more detail later in this chapter.

#### *Amalgamating clinical supervision training with other skills*

Participants called on other training they did before and after clinical supervision training. This training enhanced their supervision skills and knowledge. They emphasised that the skills they learnt in clinical supervision training were related to those learnt in nursing training and other courses. Knowledge and application of the theories of adult learning, cognitive behaviour therapy, counselling and psychodynamics were considered to be some of the important skills. One participant pointed out:

*...some years ago I decided that I would do a counsellor training ...and knew from my experience that I needed supervision training.... one of my colleagues in the team, a psychologist supervised me through that training work... so I got an understanding of what clinical supervision was. And so then went and trained... (Participant G).*

A participant who had participated in other professional development courses including a preceptorship course after his initial supervision training indicated the importance of obtaining extra skills:

*...I do a lot of education and professional development anyway and it all adds value to that... did a four day preceptor training which adds on, adds value to what you have done previously, so that was useful as well because it gives you some tips and tricks (Participant K).*

Another participant believed that previous counselling training was more important than the supervision training she received:

*I guess I had had other training [counselling] which put me in a better position to provide supervision than that specific supervision training ... I had developed counselling skills... and then as part of my nursing qualification... did a mental health major in that and did some counselling papers as well. So it was really those kinds of counselling skills that I think helped me to become a clinical supervisor (Participant L).*

### **5.2.3 Upskilling as a supervisor**

All the participants identified the need for continued professional development in clinical supervision. They believed that it was important to maintain competence and obtain more skills and knowledge around clinical supervision. Firstly, the participants were aware of the existence of formal continuing education sessions and supervision updates that were run by the employer. They identified that these were set up to provide a medium for on- going education, support and discussions around clinical supervision issues. Secondly, they identified their own informal ways of continuing education. Thirdly, participants viewed the actual process of providing clinical supervision as a means of up skilling.

#### *Formal supervision updates*

There were variable views concerning participation in supervision updates. For some participants, interactive learning and feedback from other supervisors was beneficial.

However, other participants were ambivalent about the benefits due to inadequate information and dissatisfaction with the way the sessions were run.

Four participants attended organization led clinical supervision update sessions regularly. One of the participants not only participated in the sessions, but also facilitated them:

*...throughout the year I provide supervision updates for the trained supervisors... and try and think about the benefits, why we are doing it, so you are actually reflecting on your model ,we might be doing role playing, we might be bringing in other people to do presentations... I think during the year we had 6 or 8 supervision updates throughout this past year (Participant C).*

The second participant articulated the purpose of supervision update sessions and the benefits she got from attending:

*...you are informed of any changes and that, you know, and also just to check that you are doing the right way still and that you are still on track and doing what's required (Participant E).*

The remaining nine participants who had attended some of the sessions expressed dissatisfaction with the way clinical supervision update sessions were conducted. The participants had difficulties with committing to and attending the sessions despite acknowledging their existence and purpose.

One participant who had been providing clinical supervision for more than ten years stated that she had not attended any formal update sessions because of negative feedback she had received from other supervisors:

*Well, I think the DHB has on-going training; I actually haven't managed to get there... But the feedback from that was it wasn't particularly helpful or useful but I haven't been... No I haven't had on-going training around clinical supervision since I did the training (Participant G).*

Another participant did not attend the updates due to lack of adequate information in the initial stages of him becoming a supervisor:

*...I had no idea whether to attend the supervision update. You would kind of see it there but you never put any value on it...I didn't know the policy very well and secondly because no*

*one really directed you to it...I could have gone to that supervision update if I had known but I wasn't aware of it so it was kind of fragmented (Participant F).*

A participant who had been involved in setting up the update sessions had observed that the sessions were poorly attended and doubted the benefits of sessions to the supervisors:

*...They [supervision updates] weren't particularly well attended... I don't know how useful they were for people. Probably not that useful although they could have been... the uptake was not particularly good so clearly, other people didn't think that would be useful for them when they practice (Participant D).*

However, she supported the need for the updates and emphasised that the organization needed competent supervisors. She suggested some ways of how the employer could achieve this:

*...in terms of how the organisation would check that its organisers, that its supervisors are competent, then they will continue to expose supervisors to new frameworks, new theories...continue to expose their supervisors to perhaps role modelling the supervision (Participant D).*

Another participant suggested ways of improving the running of the sessions:

*...maybe some [clinical supervision] update like... if we could have some sort of update study day on supervision and if they can bring new research and trends into that and actually do some education around it and then maybe have a little bit of time for peer support I think that would be good (Participant B).*

#### *Other learning strategies*

In addition to professional development sessions that were run by the organization, the participants identified other self initiated strategies that kept them abreast with current trends in supervision. Self directed learning initiatives and engaging in post graduate studies were stated as important factors in maintaining competence. Learning by doing supervision was another factor that enabled supervisors to learn new skills and maintain competence. One participant who had been trained to use only one supervision model obtained knowledge about other models by attending relevant conferences:

*...how can I extend my practice as a supervisor...I went to a supervision and practice development conference in the UK about 3 years ago and got exposed to a whole lot of different supervision models (Participant D).*

Another participant obtained and read relevant literature as a means of upskilling:

*I used to pull out academic papers to read about supervision... I think Te Pou sent out something about supervision, quite a thick document (Participant F).*

Participating in postgraduate study enhanced other participants' knowledge:

*I have done advanced level papers through Otago and Auckland and things like that and gained a lot more knowledge through there (Participant H).*

The exchange of information between supervisors and supervisees was considered important in that the supervisors obtained new knowledge from this process. The participants acknowledged that it was not necessary to be experts in the field of clinical supervision and that they did not have all the answers. They acknowledged that they derived new knowledge through interacting with supervisees of different backgrounds and experiences who worked in different settings, and that some of their supervisees were also supervisors.

*In supervision, people who come from different perspectives bring different wisdom with them and different questions and so forth... I get the benefit of other people's wisdom (Participant A).*

Another participant's experience of upskilling through the exchange of information was highlighted by the following statement:

*And it's good to share your knowledge and that works both ways....for the supervisors as well as the supervisee because we..., none of us know it all (Participant N).*

#### **5.2.4 Receiving supervision**

All the participants emphasised the importance of receiving formal support in the form of clinical supervision. They emphasised that clinical supervision was important for their own practice and for specific supervision skills. Participating in clinical supervision enabled them to receive the support necessary to maintain competence. They stated that supervision facilitated growth for their own practice and it also provided them with additional confidence to provide effective supervision.



One participant indicated that she used supervision as a means to facilitate reflection:

*I actually receive supervision myself ... so I think as a supervisee I can say that supervision enables me to reflect on my practice, it enables me to have to look at things a bit differently (Participant C).*

For participants working in isolation and in rural areas, supervision enabled them to check and validate their work. Participants developed strategies to ensure that they received regular supervision. A nurse who worked in a rural area developed a plan to ensure that she had access to support:

*... you're working in isolation or autonomously most of the time, 99% of the time you are out there making decisions and working on your own ... my supervision relationship was with someone that worked way up north and we used to meet halfway ... I think that the most useful thing that ever happened was having supervision for me (Participant G).*

Another participant who worked in a specialty area engaged in peer supervision as a means of sharing experiences and checking-in with counterparts in other parts of the country and overseas:

*What I have done is make sure I have those networks that can provide me with supervision, because I don't have any actual person locally...so teleconferencing is how we have regular contact but also face to face probably about four times a year (Participant L).*

Participants also sought support on issues brought to them by their own supervisees. The opportunity to discuss supervisee issues was considered an important form of support as one participant pointed out:

*... When I have a dilemma with supervision I will take it to my supervisor... that's part of my role to have supervision around my supervision (Participant N).*

Another participant stated that:

*...those are some of the things that nurses bring... and for me what do you do with some of that stuff like that you know... my supervisor now was requesting some of that to come through (Participant F).*

### **5.3 Practising supervision flexibly within frameworks**

This theme related to the supervisory relationships and to the content of clinical supervision. Participants described establishing and providing frameworks to support supervisees to develop their practice. They lay the groundwork for supervision and responded to individual supervisee needs. Participants asserted that the application of supervision knowledge and skills was essential to support the growth of the organisation and that of the supervisees. They acknowledged the theoretical frameworks that underpinned the practice of supervision. However they pointed out that they were flexible in the application of frameworks and focused more on what worked for individual supervisees:

#### ***5.3.1 Laying the foundations of the relationship***

All fifteen participants commented on the importance of sound and healthy supervisory relationships that are founded on the basis of compatibility and contracting. They emphasised that solid beginnings of supervision relationships were significant in building and sustaining trust and honesty in clinical supervision.

##### *Compatibility*

Supervisor and supervisee compatibility was considered vital in clinical supervision relationships. Setting up supervisory relationships involved one or more semi formal meetings with the supervisees that were aimed at getting to know each other:

*The first meeting is pretty much an interview of them and then an interview of me. I tell them what my particular style is of providing supervision, what my expectations are and what they can expect from me (Participant I).*

When asked about establishing supervision relationships one participant highlighted the importance of self disclosure and establishing compatibility:

*... I'm very clear that the first time we get together will be about discussing their kind of understanding of supervision, their professional orientation, what they might expect from supervision, what they would bring to supervision. I would share my orientation with them so I would say these are the things that... I expect from supervision, this is what I bring to supervision as a supervisor, these would be my expectations, these are the responsibilities I'm prepared to take, this is what I would expect from you in supervision... and also a little bit of personal self disclosure so we see whether we are a good fit or not. So that first meeting is*

*really about saying let's put it all out then have a talk about it and see whether we are going to fit well with each other (Participant D).*

Another participant highlighted the importance of taking things slowly in order to determine compatibility:

*I've always given my supervisees a couple of months to decide whether they want me as their supervisor so I won't just get them to sign a contract the first time they see me. I'll say let's have a couple of sessions and see if there is a fit (Participant N).*

### *Contracting*

The participants established ways to ensure that the expectations of clinical supervision were clear. This process involved signing contracts highlighting the principles of supervision and the boundaries involved. One participant articulated what the contract involved:

*...we negotiate a contract about how often we are going to meet, who is taking responsibility for a venue, who is taking responsibility for planning when the next one will occur. I'm very explicit with my supervisees about the things that they particularly want from supervision. What are your objectives from supervision, what do you want to bring to supervision and as part of that discussion say, it's your responsibility as a supervisee to bring this stuff to me (Participant D).*

Participants stressed the importance of ensuring the clarity of contracting around the issue of confidentiality. Whilst supervisors endeavoured to uphold the principle of confidentiality in supervision, competency, ethical, and safety concerns were considered exceptions under which confidential issues could be disclosed to management:

*If it's a specific health and safety factor I'm duty bound as a supervisor to inform their line manager and that's part of the ground work, setting down the rules of engagement at the beginning that they are aware (Participant E).*

Decisions to break confidentiality were regarded as requirements of the contracting process in the supervision policy which stated that disclosure of competency, ethical and safety concerns would override confidentiality. Another participant emphasised that:

*...that's clearly established obviously when you are in a relationship with them... if someone disclosed that they have done something entirely inappropriate or illegal or the issue is of ongoing competence, you will probably have to address that (Participant I).*

#### *Terminating supervisory relationships*

All the participants acknowledged that the supervision contracts stipulated conditions for terminating supervisory relationships. They all reiterated the importance of respecting the contractual obligations and to end relationships by either party during or at the end of a contract:

*It gets to the stage where we have mutually agreed that it's time that we parted ways and for that person to pursue another supervisor because you can get stale, you get stuck and that's what I think, and it's also part of the [policy] requirement (Participant E).*

In some instances the supervision contract would be terminated prematurely at any time by either party:

*... I said by the same token if you want to break the contract that's entirely your choice as well you know if you want to continue I'm more than happy (Participant K).*

Participants believed that terminating a contract was beneficial to both parties if it was deemed that the relationship was not growing. The following statement highlights that participants made decisions about the future of supervision relationships in consultation with supervisees:

*If it's unsuccessful for I would say 3 months, then we need to really look at things and see what's going on. It could be that's in the wrong and I'm missing you [the supervisee], it could be you in the wrong and you're missing me (Participant K).*

Factors beyond the supervisors' control were highlighted as other reasons for terminating relationships. Contracts would be terminated if the supervisor or supervisee left the DHB or if one party became line manager for the other. As illustrated in the following statement, close proximity to supervisee was also noted to be counterproductive and justified terminating the contract:

*...they are now on [location removed] and I'm up on [location removed] so it's a little bit complicated and I've actually asked them to think about do you want to carry on supervision*

*with me or do you want to find someone else?, so I've left them to think about it (Participant B).*

### **5.3.2 Sharing responsibilities**

Sharing responsibilities was a central feature in supervisory relationships. Participants emphasised the importance of active participation by both supervisors and supervisees. They described the nature of the relationship as one of being on 'equal footing' but with individual responsibilities.

One participant acknowledged that although roles between supervisors and supervisees were different, their responsibilities in supervision were equal:

*We might be in different roles [supervisor and supervisee] but we are all equal. I might have more responsibility for certain things and that's fine... but most of the times I want to think that we are all on the same footing (Participant J).*

Another participant reiterated that accountability was shared between supervisors and supervisees:

*You [supervisor] have some accountability... it's probably shared accountability and they have got some... yes they [supervisees] have got accountability too (Participant O).*

*The responsibility very much lies with the supervisee. And yet I have heard that different models would say that nurses who are supervisors are responsible. I believe I'm responsible for any information that I give out to people and for specific interventions that I may suggest (Participant N).*

#### *Preparing for supervision*

Being prepared and preparing for supervision was considered important to the relationship. Participants expected supervisees to come to the sessions prepared just as the supervisors also came prepared. In addition to the knowledge and skills acquired through training, participants physically and mentally prepared for supervision sessions in order to meet specific needs of the supervisees. Preparing was considered to enhance the quality of the supervision they delivered:

*I can plan ahead because once I have that [supervision] slot, I put it in my diary...sometimes I have to familiarise myself with an area that I have no experience in (Participant M).*

The above statement indicated that the participants acknowledged their limitations and prepared themselves for supervision by researching about their supervisees' areas of work.

Preparing for supervision required participants to be 'present':

*I like to stop for ten or fifteen minutes before I supervise somebody, just to have a little think just to refresh myself, to cleanse my palate if you like before we go in (Participant D).*

Another participant ensured that they totally participated in supervision by physically and mentally removing themselves from their place of work:

*I want to come and be here, I don't want to be thinking about stuff that I should have done that I haven't got done or that I've got to do next... Being allowed to be here and attend to what is going on here, rather than being somewhere else (Participant A).*

Preparing for supervision was also expected of the supervisees to but it was acknowledged that this did not always occur:

*... The supervisee finds it difficult to prepare themselves adequately, to have clinical things to bring to supervision (Participant D).*

Another participant expressed frustration at supervisees who did not prepare for supervision:

*... People come without really having thought about what they want to address or what they want to talk about. I do expect them to come having done some reflection before they come about what they are going to bring... I think that people should out of respect for the supervision process have thought a bit about what they want to bring (Participant N).*

### *Educating supervisees*

Participants discovered that clinical supervision was poorly understood by the majority of supervisees:

*I sometimes wonder how much nurses value supervision and how much they understand about why it's so important (Participant N).*

Participants believed this to be the reason why supervisees often came unprepared for supervision. Educating supervisees about clinical supervision became one of the supervisors' tasks before they could delve into actual supervision. The aim of giving education was to ensure that supervisees responded and participated in a responsible manner:

*I'd like them to have some sort of understanding of what supervision is and I usually try and explain that to them... and getting them to come up with the answers and not just expecting me to answer everything and you know it's about them actually thinking about things and problem solving (Participant B).*

Another participant combined education and supervision skills to keep supervision focused:

*...there is some education about you know what you are requiring of them, get them prepared with an issue and being prepared to talk about that in depth... helping to keep them focusing and clarifying just asking lots of questions about what is the issue and is that what we are discussing today and just keep trying to get some clarity about what is it that they are wanting and what they are wanting to achieve by the end of the session (Participant O).*

#### *Deciding when to lead in supervision*

Participants acknowledged that the content and focus of supervision lay with what the supervisee brought to supervision rather than with what the supervisor or the DHB required. This posed a challenge for the participants when they were faced with situations that required them to take the lead. This was evident in the way the participants applied various approaches to ensure that the content of supervision met specific supervisee needs. One participant commented that:

*I just believe that I can only act on what people tell me... I believe that they are responsible for their practice, they are responsible for coming to supervision and they are responsible for telling me what they believe is important for them (Participant N).*

Another participant used a more direct approach and was more active in the relationship. She used different approaches depending on the role she played at the time of supervision:

*When I'm a supervisor I, there's two ways of doing it. One is I might just to take the brief notes from a previous session and say look last time you spoke about this... How is it now? So I might actually track it back and see if they've followed up. Alternatively I might say we just start having a conversation and something comes up, or I might be more direct and say well ok have you got something you want to bring today?(Participant C).*

Another participant had a different view.

*The supervisee determines the direction of supervision and the pace of supervision, but the content is more of a shared thing... you run the risk of just sitting around chatting about the weather and not actually getting any work done... there needs to be some framework and direction around it. It needs primarily to be work focussed kind of thing; it needs to be useful in terms of the person's work (Participant A).*

This statement embraces the notion that whilst the supervisor accepted that the supervisee had control of what they brought to supervision, the supervisor held some responsibilities on the outcomes of the session.

The participants' view that content of supervision is a shared responsibility leads to the next section in which participants state different views regarding the contents of supervision.

#### *Not doing it for the supervisee*

Implicit in this finding was that participants considered their role in supervision as that of facilitator and supporter, and not someone who would just give answers:

*You are there at the end of the day to support that person as well as you can and support their practice and that includes pointing out where there's shortfalls (Participant I).*

*...To really stand back from advising and trying to get the supervisee to come up with the answers or the directions that they are heading (Participant O).*

*I'll walk alongside them if that's what they want me to do but I won't do their work for them. I've to remind myself, no you are not doing it because it's for them to move through... I'll support them I'll provide perhaps some strategies or for example if there is some theory and it maybe policy and procedure then they can go back and work through that (Participant J).*

Another participant asked questions in order to stimulate the supervisee's thinking:

*I can offer some opinions and suggestions and would hope I can ask some useful questions along the way, but I don't know. I don't have any cosmic secret answers... my job is to ask questions more than anything else (Participant A).*

#### *Facilitating reflection*

Participants believed that by facilitating reflection, the supervisees grew through their own learning. Reflection allowed for the examination of existing thoughts and behaviours and the creation of new ones:



*It's absolutely vital that it's a place, a safe place where nurses can go to be heard and reflect on their practice and to find training needs or understanding of what they're doing (Participant G).*

*I actually wanted her to use supervision for reflection and looking at problem solving (Participant B).*

One participant described how reflection helped in learning strategies of how to do things differently:

*...to have to look at things a bit differently... I think that even just reflecting on practice and being able to say well actually that wasn't necessarily a good outcome but it was the best considering the circumstances (Participant C).*

#### *Validating practice*

Linked to reflection was that supervision provided a place for affirmation and validation of supervisees' practice, anxieties, conflicts and achievements. Participants perceived supervision to be a place for offloading one's difficulties. However all the participants commented that because of the stressful nature of mental health nursing, supervisee validation provided support in times of difficulties but more importantly in celebrating achievements:

*...Validating your practice and making your supervisee, or myself as a supervisee, feel yes I am doing ok within the organisation or my profession, or looking at the nursing domains (Participant C).*

One participant commented on the benefits of validating practice:

*People leave supervision feeling that they have been heard and that they have had their concerns listened to and that, I hope that they feel restored if they've got any issues (Participant N).*

#### *Providing knowledge and information*

Provision of knowledge was also about sharing with supervisees to enable them to do the work or to improve on some aspects of their practice. For one participant, knowledge of cognitive behaviour therapy enabled them to assist supervisees who worked with clients with borderline personality disorders:

*... my main area and interest is like borderline personality disorder... we've actually problem solved and come up with different interventions for the clients and when I've used the CBT 5 part model into supervision, those nurses have actually gone back and done 5 part models with clients which is nice, that they feel competent enough to do that so it's kind of teaching them some skills to make them feel a bit better in their practice (Participant B).*

Another nurse sourced information on behalf of a group of nurses who wanted to embark on peer supervision:

*...another team that requested how to do peer supervision so we took academic data to them and explained to them how the team that I worked in used it and so what I have heard is that that team is using it and it seems to be working well (Participant F).*

### **5.3.3 Focusing on clinical issues in supervision**

The DHB required that supervision be linked to clinical issues. All the participants commented that whilst their supervision training focused on clinical issues, they were often unclear when it came to defining what the organization required of them in terms of the subject matter. Participants identified that in addition to clinical matters, supervisees often brought managerial and personal issues to supervision.

Participants attempted to work through clinically related supervision while acknowledging that supervisees often brought up managerial and personal matters:

*...the focus is on clinical supervision and what is happening in practice...Some of these things may cross over and touch but the focus is here [clinical supervision]...so I know the patient needs to be in the picture all the time (Participant F).*

Participants maintained that the purpose of clinical supervision was to provide support with any issues that enabled supervisees to grow in their nursing practice. They identified different strategies to address issues that were not clinically related to ensure that the needs of the supervisees were met:

*If a supervisee brings issues that they have with the manager, then I would strongly encourage that they use the right process to address that. Might be facilitating a meeting with the manager and if stuff comes up which suggests that they need personal counselling then I would recommend EAP [Employment Assistance Programmes] you know (Participant G).*

A participant acknowledged the difficulties associated with management issues in supervision and found ways of addressing this dilemma:

*Lots of management issues are brought to the table. Although it does impact on patients care for me it starts to become an issue because the way I have been coached is to focus on clinical issues but through my practice I'm realising that well, we've got to also incorporate a bit of the management stuff because that's where the nurses want and bringing it back into the clinical on how that stuff is affecting the patient (Participant F).*

Another participant felt strongly about separating clinical from managerial issues:

*I work very hard at making it clinical and it's quite a challenge for some of the people to retain that awareness ... we are not moaning about the organisation we're really, we can look at some challenges which may also impact on clients, but it's really not about management and the organisation (Participant C).*

For another participant the focus of supervision was not always around clinical issues. Rather, the focus was determined by the level of supervisee experiences for which the supervisor had no control:

*The junior nurses are.....a lot of the conversation is purely related to clinical practice and clinical situations whereas the longer serving staff, the issues is usually a bit different and often slightly more complex where the clinical practice itself isn't really the key issue (Participant I).*

#### **5.3.4 Adopting a flexible approach**

Participants were aware of their supervisee differences and they articulated how they used these differences in supervision. They spoke about how sessions would be tailored to suit individuals or groups while at the same time acknowledging the complexities surrounding this. They articulated how they accommodated and worked with supervisee differences and highlighted these in the use of supervision models and working with different levels of work experiences.

##### *Applying different models of supervision*

Flexibility was also exercised in relation to the eclectic use of supervision models. Most of the participants adapted other supervision models to complement those learnt during supervision training. Although the participants stated their points of view differently, the

following extract encapsulates the essence of how they considered that models could be used in a fluid fashion:

*...It's actually sort of ok to go outside the square a little bit, not necessarily follow the step wise process like that. You've sort of got to take it [the model] on the run a little bit, it depends on what that person needs to discuss on that day and things like that ....In some ways over the years I have moved quite a reasonable distance away from that original model and I wouldn't like to say that I use one particular model for supervision any more it's a little bit eclectic as such... (Participant H).*

Participant J commented that:

*I'm not saying that we should all be using the same model because I think that it's important we see what works well for us. I like the TAPES because I know the TAPES but I know that there are other models.*

*...the TAPES model... I find that quite helpful. Sometimes I just use the Proctor's restorative normative, formative... Sometimes, particularly with people who aren't particularly good at reflecting on their own, I might use a model that is in the Professional Development Recognition Programme...it is a reflective model. So it actually helps you to think, ok, if you are going to reflect on a situation this is where you start and this is where you go next. So it's about analysis. Sometimes that works really well for people who are quite new and don't have that framework for reflecting by themselves (Participant D).*

Participants applied other techniques and models whilst working within a model of supervision:

*I enjoy having a framework, I'm comfortable having that TAPES model with the framework, but also I don't follow it rigidly so I will bring in other things, so although I did the TAPES training it's probably more of an eclectic mix that I do really (Participant C).*

Another participant incorporated psycho-therapeutic and teaching models into her supervision:

*It's just an integrated approach really. When I think of the models I draw on in supervision I will be drawing on adult learning theory, I will be drawing on counselling models, my*

*understanding of personality theory and of course models around beginning to advanced practitioner (Participant L).*

#### *Adapting to different levels of clinical and nursing experience*

Participants employed different approaches to supervision in relation to supervisees' work experiences. The supervisees' place in their careers influenced the way they understood clinical supervision and their expectations of it and that the supervisors responded to the different levels of expertise accordingly. The following excerpts highlight this:

*...When you are dealing with people who have much less experience, you need to be more delicate about the listening, the talking, the engaging and take longer and allow them time to bring the issues forward. It takes a little bit longer but it's nonetheless valuable. It's just a different approach... (Participant K)*

Another participant added that:

*You know people who have been in the business a bit longer tend to be a bit better at separating that stuff out, whereas your beginning practitioner is likely to be a bit more muddled about it all and so that has a bit of an impact on the way you work with people (Participant A).*

*I think that supervisors have to be aware that there is a power differential. The obvious example is when you're supervising people that maybe less experienced who often come looking for the answer (Participant D).*

The nurses felt that it was important to cater for individual needs as and when they arose. Although aware of the policies and procedures around clinical supervision, most participants used them as guidelines while they applied their own individual skills to the process. The supervisee was acknowledged as unique and multifaceted and the supervisors identified ways to respond to the supervisees' differences.

## **5.4 Integrating clinical supervision and nursing practice**

The essence of this theme was that the skills and knowledge for clinical supervision and mental health nursing practice are interconnected and that each practice informed the other. Throughout the interviews participants spoke of the connection between their mental health

nursing practice and their roles as clinical supervisors. Three processes contributed to this interconnection; building on personal and professional attributes and skills, developing own nursing practice through providing supervision, and applying tools of supervision to practice.

#### ***5.4.1 Building on personal and professional attributes and skills***

This aspect related to professional and personal qualities that participants identified as contributing to their ability to provide supervision. Combining professional and personal attributes was considered important in adding value to the role of supervisor.

##### *Attributes*

Participants identified personal attributes that enhanced their supervision. They were attributes that underpinned their mental health nursing practice. One participant noted that:

*I'm good at reflecting, I'm good at the listening, I'm good at the pulling, extracting. I have also quite often used the miracle question, I'm good at clarifying, and I make myself be good at listening (Participant C).*

Another participant reflected:

*I think being friendly and kind of being inquisitive...and just being non judgemental (Participant N).*

Another participant highlighted the importance of being a 'people person':

*I just enjoy people. Just an interest in people and that would be the main thing... I could not do it if I was self centred and I didn't give a damn about anybody else but I actually really like other people and I really enjoy listening to their stories and their journeys and their issues (Participant E).*

Perseverance was also an important attribute described by the participants. The ability to 'always be there' and '...to just keep doing it...'sustained supervisors' the enthusiasm to continue supervising even when the work environment was challenging. The following excerpts illustrate this commitment:

*Just keep doing it. Despite all of those things, just keep doing it. Sometimes I find it quite frustrating and quite pathetic but that's no good enough reason to walk away... you still make yourself available (Participant I).*

*... I'm always there even if they're not there [supervisees ] Sometimes it's frustrating, It's like the day I turned up to the group and I waited and nobody turned up (Participant C).*

#### *Clinical skills and knowledge*

All the participants spoke about how they applied their practical and theoretical knowledge of nursing to their work as clinical supervisors. This theory and skills were included within their nursing training and later, in therapy courses. Some participants commented that supervision skills and knowledge were a continuation of those that they had learnt in their nursing training:

*I think it [clinical supervision] was just sort of integrated into our [mental health nursing] training really (Participant D).*

Other participants applied the knowledge learnt in nursing training to supervision and believed that clinical supervision built on those existing nursing principles:

*...it's [clinical supervision] a continuation as much as anything... It's a bit like the stuff that you learn back in Nursing school... some of that is still useful nowadays too, so you build on knowledge rather than discard stuff from the past (Participant A).*

*I think the clinical supervision helps with the nursing skills and I think the nursing skills help with the clinical supervision because the clinical supervision is associated to nursing (Participant K).*

Another participant described how they linked clinical supervision to a particular talking therapy intervention they used in their nursing practice:

*..what I was taught then about how you go about clinical supervision, what the idea is behind it, and it was almost like my goodness, this is as much as Cognitive Behaviour Therapy (Participant H).*

#### *Other professional skills and knowledge*

Participants reiterated that clinical supervision was not an isolated entity, and that they drew on skills and knowledge learned in their various professional roles.

One nurse drew on her role as a union delegate to provide information and education around employment and disciplinary issues during supervision. The participant stated that:

*I'm the union delegate as well... human resource type policies and procedures and where people can get help from... I have an awareness of those things that I can call on if I need to... in my years of supervising I've kind of felt concerned the risks that people leave themselves open to. It was more of a sharing of knowledge and putting it back to the nurse involved that they could be criticised in some way or could be at risk (Participant N).*

Others held teaching roles that gave them experience in educational processes which they applied in supervision. One used her experience of group facilitation:

*...it's actually a whole group facilitation process as well as the supervision. It's a whole lot different to if there's just say 2 of us in the room... you have to bring different skills (Participant C).*

One participant who was also a preceptor of new students and new staff members used supervision for education when she identified gaps in the supervisee's learning:

*I was kind of teaching within the supervision... I wanted her to come up with some solutions too but there weren't any so that was when I did a bit of teaching within the session (Participant G).*

Another participant was able to extent her role in supervision because she held a relevant academic qualification that enabled her to provide supervision to nurses working in a specialty area:

*I feel sort of competent to supervise them because I've also done an advanced certificate in dual diagnosis so I understand some of the issues related to drug and alcohol (Participant G).*

#### **5.4.2 Developing own nursing practice through providing supervision**

Participants reflected that they developed as individuals and as mental health nurses through the process of providing clinical supervision. One nurse noted:

*I'm probably more capable or a better individual for providing clinical supervision now because of the practice that I've got behind (Participant I).*

All the participants acknowledged that working with health professionals from different settings, backgrounds and experiences exposed them to new knowledge. Supervisors



indicated that they learnt from supervisees' questions and curiosity just as much as the supervisees learnt from them.

The essence of this is highlighted in the following statement:

*People ask me difficult questions and I have to go away and think about them. I get to think about and consider the challenges that other people face as well as the challenges that I face in my work and I guess it's a bit like vicarious experience you know, I get exposed to dilemmas that I don't actually have to live through in order to think about and consider and I get the benefit of other people's wisdom as well... people who come from different perspectives bring different wisdom with them and different questions and so forth so yes, I think it's a great benefit (Participant A ).*

Supervisors were often prompted to look up literature for their supervisees. In doing so, they consolidated and extended their own knowledge:

*But certainly when you do supervision and you do it in the right way you get a lot of value from it. So I find it really beneficial for my own practice ...and a bit of the academic staff. I used to pull out academic papers to read about supervision (Participant F).*

Finding answers to clinical situations was a shared task that benefited both supervisee and supervisor:

*... if they [supervisee] ask me some stuff and I don't know the answer I can go and find out and you [supervisee] can go and do some research and come back and we'll come back and talk about it So it makes me think, which is good you know it keeps me on my toes (Participant B).*

Most participants discovered that providing supervision allowed them to create networks across the organisation for information gathering and learning. Nurses working in isolated and specialty areas particularly benefitted from the contact they had with other people during supervision. One participant noted:

*... it's a way of getting to know what happens in the other parts of the service because you do get out of touch especially where I work... it's good to have knowledge sharing (Participant N).*

### **5.4.3 Applying tools of clinical supervision to practice**

Participants pointed out that they were able to transfer tools of supervision into their clinical practice. A participant explained how she used the TAPES model in her clinical work:

*So that to me links straight back to my practice. Whenever there are any issues I always try to resolve my own issues... sure I'll take things to supervision but in the meantime I use TAPES model on myself in order to try and work things through (Participant J).*

Another participant encouraged her supervisees to apply the model to their own practice:

*if we use this model today and you see what this model looks like then you can take that and use it in your own practice and this is something you can do when you've come across a situation that you don't feel has been resolved. Particularly when you can use this yourself, by yourself and think through it (Participant D).*

An experienced nurse supervisor adapted clinical supervision skills for use in his clinical work and in other settings:

*..the skills I learnt in that initial supervision courses are things that can actually be used in a huge number of different arenas, not just solely for clinical supervision and to a great deal I sort of find myself even these days when I'm talking with mental health clients, I'm bringing some of these skills into that interaction as well as into the clinical supervision (Participant H).*

## **5.5 Working within organisational frameworks**

This theme relates to how the DHB's organisational frameworks and practices affected the clinical supervisors. The findings are presented in three parts. The first part describes how the participants managed the tensions between organisational policies and procedures that were ambiguously implemented. The second part relates to the effect of organisational constraints on clinical supervision. In the third part, the participants identified the DHB's systems and processes that enabled them to provide clinical supervision.

### **5.5.1 Responding to ambiguous policies**

Tensions emerged as those issues that supervisors regarded as actions and expectations from the organization that posed potential conflict, apprehension and ill feelings within clinical

supervision. The three areas identified by the participants were mandatory supervision, involvement of management in clinical supervision and ownership of supervision documentation.

#### *Mandated clinical supervision*

The District Health Board policy on clinical supervision required all mental health and addictions nurses to engage in supervision. However, the DHB appeared ambivalent about whether supervision should be mandatory. The policy was loosely applied; leaving the nurses to manage the tension between the desire to ensure that they practised safely and developed professionally with the reality that supervision was not available for all clinicians. Lack of clarity, poor communication and limited practical support affected the uptake of supervision by nurses.

Participants noted the gap between the supervision policy and the actual practice of supervision:

*...the culture of our organisation is that we will have supervision and people are becoming more comfortable with it... even though it's supposed to be mandatory over the past few years it hasn't been enforced... it shouldn't have to be skipping through hoops to do it and it should be mandatory (Participant C).*

Organisational procedures did not always support the practice of supervision. One participant commented on the lack of a clear supervision definition that would enable nurses to understand the need to participate:

*Our policy defines it to some degree, so internally we have got sort of a shared very loose definition of what it is. So yes it's mandated but it doesn't define it, so for in-patient nurses many of them do argue that it's unnecessary because they are in a group team environment where they are constantly getting feedback and oversight on their work (Participant O).*

Another participant noted an absence of clear guidelines around the process of ensuring that all mental health professionals had access to supervision:

*... just even the whole framework about where the supervision list is, who holds it and are people actually following a real process ... It's not a clear formal process (Participant C).*

Participants had mixed views about the mandatory nature of supervision.

One participant suggested the extension of supervision to untrained staff:

*The other thing I would change is I would make it compulsory for everybody and not just the registered nurses but also the nurse assistants as well as nurse aides (Participant I).*

Other participants questioned the wisdom of compulsion in relation to clinical supervision. One claimed that supervision should be a matter of choice:

*Clinical supervision... I guess that's their choice, it's not a mandatory thing you can't really force people (Participant K).*

Although mandatory supervision was in place theoretically, organisational procedures did not support participation in supervision. There were mixed views as to whether supervision should be compulsory or not. The uptake of clinical supervision within the DHB was therefore limited.

#### *Involving management in clinical supervision*

Whilst some participants acknowledged that some aspects of management involvement in supervision were necessary, sentiments expressed by most participants challenged the effectiveness of involving managers in supervision.

It was not always clear whether management processes should be included in clinical supervision. Whilst the DHB policy on clinical supervision stated that supervision contents and outcomes were confidential it required the reporting of ethical and safety concerns to management. All but one participant [line manager] viewed reporting supervision to management as not only working against the supervision policy and the principle of confidentiality but also as a covert way of performance surveillance. Participants felt that it was for this reason many health professionals were reluctant to engage in supervision:

*I think it's just that they don't find it [clinical supervision] interesting or appealing for whatever reason that might be. I still see people working here without it (Participant K).*

Participants identified that reporting to management could be counter-productive to effective supervision:

*I think that actually constraints supervision... it doesn't make it entirely worthless but it certainly is not as effective as it should be and it kind of overrides the principles I was given*

*about what supervision is and what it's for...I make sure that they [supervisees] are aware that this isn't private anymore and therefore it isn't really clinical supervision (Participant I).*

Most participants believed that performance management should be separated from supervision. They considered the role of management as that of providing frameworks and support and not getting involved in the actual supervision. Where indicated, reporting to management should have a separate place and process:

*I recognise the difference between management supervision and clinical supervision so that if a supervisee brings issues that they have with the manager then I would strongly encourage that they use the right process to address that (Participant G).*

*I have been involved in the odd incident where people have had performance reviews and performance plans done for them... I've had to write a report that they have attended supervision (Participant N).*

However, line managers' involvement in supervision was regarded as a supportive role when it was related to providing resources:

*It needs to be supported by the managers, because the managers have the funding... if the managers don't provide or approve the funding and the leave, how can people learn to be supervisors, how are they then going to support someone to go off you know off site or to have people come along to do supervision (Participant C).*

At times, the organisation required a staff member to engage in supervision as part of performance management process. Providing supervision in response to management request highlighted some difficulties for some participants:

*...A senior nurse was just meeting a requirement from a management perspective... I felt quite cheated by this nurse. She came and saw me three times I think and requested a letter to say she is in supervision... we just had a chat kind of supervision... And once she had that letter and her issue resolved she disappeared (Participant F).*

One participant who happened to be a manager strongly advocated for supervision to be reported to management. She pointed out that apart from providing support; line management had an important place in supervision. She believed that linking clinical supervision with line

management was regarded as a means through which the organisation would monitor the development of the supervisees, provide the necessary resources and obtain feedback:

*I know that the supervision session is confidential and all that however there has got to be some feedback mechanism so that the person who is line managing is aware of what people's training needs are and what the plan is around supporting those needs rather than having it happening out there in isolation, and what direction is this person heading in and is that in line with the organization's goals... that's where it needs to be that link with line manager at least flagging some issues...and that sort of set up between clinical manager and the supervisor and the supervisee (Participant L).*

#### *Ownership of supervision documentation*

The DHB policy on documentation in supervision required supervisors to write up notes to capture the highlights of each supervision session. These notes were deemed to be the property of the DHB to whom they would be surrendered on request and when the supervisees left employment. At the time of the study, the policy was under review. Therefore the findings reflect the experiences of the nurses before the policy review.

All participants identified that the tension about supervision notes lay with what happened with the notes rather than the actual documentation. Participants were clear that they kept notes only for the purposes of the supervisee reminders and checklists rather than for use by the DHB.

One participant who questioned the intentions of the DHB wrote notes but did not comply with the request to submit them:

*...I think the DHB requires the notes to be sent to them when the supervision closes and I absolutely do not agree with that...Because it's a private place for safety for clinicians to identify strengths, weaknesses, ethics... I don't believe that it's the property for the wider DHB. I don't know that anyone would, I don't know why they would want the notes. What are they going to do with them? I know that's in the policy but I don't abide by it (Participant G).*

One participant was suspicious about the purpose of keeping notes and felt that the organisation used documentation to scrutinize both the supervisors' and supervisees' work:

*...What happens to the information, your clinical supervision notes... we are supposed to just highlight a few points around what transpired in that session... So I suppose that uncertainty*

*about information for the other person is something that doesn't quite sit right. ... It's not paranoia but its not clear cut, it's not black and white (Participant J).*

### **5.5.2 Working within organisational constraints**

Providing clinical supervision involved '*fitting it in with all the other things*'. This meant that participants took on supervision as an additional role to their workloads and attempted to work around some difficulties. Participants identified five elements that they considered as constraints in their efforts to provide clinical supervision; supervisor availability, making time for clinical supervision, supervising colleagues and groups, and accessing appropriate venues.

#### *Supervisor availability*

Inadequate human resources meant that there were not enough clinical supervisors in the mental health and addictions service. At the time of the study 48 nurses were practising as supervisors in the DHB that employs over 300 mental health and addictions nurses. According to the supervision policy, the recommended ratio of supervisors to supervisees is one supervisor to three supervisees. Participants were aware of the limited number of available supervisors in the DHB and acknowledged the problems associated with finding a supervisor who had room:

*I know it's not an extensive list and I know when I'm asking my staff to find a clinical supervisor they struggle to find someone who's got availability on that list (Participant L).*

Sometimes supervisors were under pressure to take on more supervisees in order to accommodate those seeking supervision:

*I've got two people that I supervise at the moment and I have a lot of people coming up to me saying will you take a third one (Participant B).*

Other participants took on more than the recommended number of supervisees:

*I'm actually overwhelmed with the amount of people requesting supervision... I've got four people that I'm supervising (Participant F).*

At other times the supervisors were not able to terminate supervisory relationships after every two to three years as required by the policy because there were no other available supervisors to take on the supervisees. Participants admitted that while they acknowledged the need to

move people on, they were sometimes under pressure to extend supervisory relationships if no other supervisors were available:

*I have never come to a point where I have either severed a relationship, we do review, should we be continuing, but we carry on, we've redone our contracts more recently (Participant J).*

Poor communication systems exacerbated the problem of supervisor availability. Potential supervisees lost out because there were no clear processes of identifying available supervisors. Trying to access a supervisor was described as a running around from pillar to post experience. One participant commented:

*It's all ad hoc, like nobody else has got any room. It's a real dilemma I think...it's a real issue for me. We have policy, we are supposed to be providing this, and it takes people a good six months of being in the service or more before they can locate anybody to provide supervision (Participant L).*

The participant suggested some ways of identifying and accessing supervisors:

*There needs to be a clinical supervision website that people can go to and read about each person and their areas of expertise and their qualifications on our intranet and then they choose and they can go and discuss it with somebody (Participant L).*

#### *Making time for clinical supervision*

Linked to poor communication was the problem of clinical release and attendance. Participants expressed different experiences with attending supervision. Even as the supervisors strove to fit supervision into their schedules, creating a balance between supervision and workload management was described as a challenge. Supervision appeared to become marginalised in favour of other activities as indicated in the following statement:

*I have had an awful lot of appointments broken and I have also broken an awful lot of supervision appointments because it's just very difficult to get the time out of your schedule and if it comes to a choice between clinical supervision and pretty much anything else, the clinical supervision is going to be zapped (Participant I).*

Some supervisors observed that nurses who work in community settings appeared to access supervision more often than their in-patient counterparts. One participant's view was that community nurses worked in isolation, therefore they required more support through clinical



supervision compared to in-patient nurses who had immediate support from colleagues and ward managers:

*I think that for community staff, looking at it I could say it's because you work a lot more alone. And so there is a greater need to talk through some of those issues when you working alone with your clients, whereas in-patient you are constantly discussing with peers and other MDTs (Participant O).*

Another participant offered a different view. The participant felt that in-patient staff experienced more stress and burnout but they were not able to access supervision readily because of the busyness of the wards.

*Sometimes busyness of the ward, you just cannot physically get away so you are stuck and I've had to cancel supervision or change it (Participant B).*

Where clinical supervision was perceived to be an imposition, attendances were more erratic. For nurses supervising untrained staff, it was unclear who was responsible for making sure that appointments were upheld. This comment was made by a supervisor of untrained staff who felt that power and communication issues impacted on regular attendances:

*... whether [supervisees] they're allowed to come or whether they are prevented or whether they chose to so I keep running it, there were nine last week, and the month before there was no-one, the month before that was two, the month before that there was seven (Participant C).*

Disparities in attendances were also linked to shift work and rosters:

*I have had people on night shift that have been really quite hard to get a hold of. Umm and their hours really don't work very well with the supervision process (Participant N).*

All the participants felt that the differences in work schedules between community and inpatient nurses influenced the supervisees' access to supervision with community nurses attending more supervision than their counterparts on the wards.

#### *Supervising colleagues and subordinates*

The mental health and addictions service is small and it has a small pool of supervisors. As a result participants often supervised people who were well known to them and many had worked with each other. They defined colleague as someone working in the same team.

Participants had advocated for external supervision as a solution to this problem but the organisation had restrictions on who could access external supervision:

*...outside would have been my first choice but that needs approval and I have discussed it and told to look inside... it has to be internal because with the external...well there is payment obviously, it needs to be approved (Participant O).*

The revolving nature of the clientele also meant that some discussions were likely to involve people or clients that were already known to the supervisors:

*I can pick up really quickly which clients they are if its clients that I've nursed and yes they've been problematic, sometimes it's a good thing for me to know who it is, but it's good to remain objective to your own experience... and again if they get really critical of their colleagues I can usually pick up who they are talking about and that can be really uncomfortable so sometimes it's a bit too close to home (Participant B).*

Participants identified that professional boundaries ensured that supervision did not occur between friends, partners or people working in the same team:

*I don't think it would be reasonable for me to supervise people in my own team... it would be better that they go and see somebody else but I happily supervise people from other teams (Participant A).*

The participants described that supervising their own colleagues clouded objectivity and impartiality:

*I think it's incestuous to have somebody from your own service being your supervisor and I don't think it's healthy because you got too much in common (Participant K).*

*I think that having two or three people in one team supervising each other is very nepotistic and you get nowhere. Usually you bounce ideas off your own colleagues anyway so it's best to get a neutral person outside so you get fresh eyes and ears so they don't come with their own agenda with their own preconceived understanding or knowledge of the processes and concepts of what's going on within the team already and that could influence the process of supervision or impact on the supervision or productive supervision session (Participant E).*

Most of the nurses said that the power of good supervision lay in the ability to ask questions without prior assumptions or knowledge. A participant explained:

*I think for me the further removed you are I think the better supervision you can give, and it's just about asking, being able to ask things and get clarity from them without knowing the situation...it's helpful to be able to ask more naive questions in people that are from a different area and also that you are not too close and it doesn't become kind of personal... very clear what your supervision role is and it doesn't have to be friendship or a chat over of coffee but much more formalised and I think that helps with that separation (Participant O).*

One participant with a different view acknowledged the complexity surrounding the immediacy of colleagues but regarded receiving supervision from a colleague as an honour:

*I think it's generally a privilege actually particularly if someone approaches you and asks you for supervision. Because to a certain extent I think it says that they value the way that you practise and you would like in some way to balance themselves against the way that you do things. Sounds awfully egotistical but that's actually the way I select a supervisor for myself. Its somebody's practice I respect, their knowledge base (Participant I).*

Line managers who were also supervisors spoke against supervising their subordinates:

*I just think it's unethical... certainly as a line manager I wouldn't be trying to do clinical supervision with a nurse in my team but similarly I prefer that my nurses in my team that I'm line manager for be supervised from someone from another team not from within the same team, if possible, when possible (Participant G).*

### *Supervising groups*

Lack of enough supervisors meant that some nurses were required to provide group supervision. Supervisors of groups provided supervision to both qualified and untrained staff. They added that they had not received any specific training for this role and conceded that this process was a further extension of their roles. Supervisors found that they needed to incorporate expanded skills of group facilitation. One participant who provided group supervision described the skills and dynamics of working with groups:

*It's actually a whole group facilitation process as well as the supervision... It's a whole lot different to if there's just say two of us in the room and one person is talking..., yes they are different, you have to bring different skills ...but you can't be too focussed and too formal with those people because there's a lot of people in the room at all different levels and from*

*different wards so it's just trying to get some commonality and perhaps some support for those people, so it's a bit different (Participant C).*

#### *Access to appropriate venues*

The need for privacy and confidentiality was an important principle of supervision, however most participants struggled to find appropriate venues to meet this requirement. The choice and suitability of the venues depended on the type of work settings and distances between supervisors and supervisees. Some work settings were difficult to access due to security reasons whilst other venues were too far away, too close or too noisy. One participant stated that:

*...just finding a venue is difficult. A room that you can safely disclose or something like that without interruption...because everybody that I supervise is actually in inpatient... that has made it difficult. I would draw people out of the ward setting because I don't think it's good to have it on the ward where they are working. I like them to be totally away so that they are not distracted at all (Participant J).*

Some participants made their own efforts to identify and provide more appropriate venues to ensure that supervision took place despite the difficulties associated with being busy or being too far. A participant who worked in a secure unit commented:

*I'm starting to leave to go to different areas to meet people because they can't always get away... I can usually negotiate it here, to say look, I have to go and meet this person where they are working because they can't actually get away because it's too busy. And if I don't go there then they miss the opportunity...I have always said... if you can't get away, just ring me and I'll see if I can come up (Participant K).*

Whilst the nurses valued the importance of working under the guidelines of organisational frameworks, they also felt constrained in some aspects. The ability to perform clinical supervision within the organisational frameworks related to the supervisor's abilities to use their knowledge and skills cautiously and creatively.

#### **5.5.3 Benefitting from organisational systems**

All the nurses identified some extrinsic and intrinsic factors that enabled them to provide clinical supervision in the DHB. Organisational support and the recognition of themselves as autonomous practitioners were important factors that supported supervisors.

Various forms of support from the organization enabled participants to give supervision. Support from clinical managers meant that the supervisors were able to give supervision with the knowledge that they were supported:

*...having support from your team leader to actually go and do supervision ... my team leader at the moment, yes he is quite supportive and I can say look I'm going for supervision for an hour, and he's like ok off you go and he'll cover you so that's good (Participant B).*

The ability of the organisation to fund training and paid leave was mentioned as a major factor in making supervision possible. The acquisition of skills and knowledge enabled supervisors to apply evidence- based theories and practices into a range of interventions such as group dynamics, reflection, communication, listening and self-awareness.

In addition, the organisation provided other resources in the form of policies and procedures to guide the supervision process, time and transport for supervisors to travel to intended venues.

The ability of participants to self regulate indicated that the nurses were able to be pro-active in terms of the supervision process. Self regulation permitted the nurses to identify their own strengths and limitations and enabled them to perform their duties creatively while maintaining the integrity of their profession and the tasks assigned to them. One participant stated:

*I'm allowed to practice very independently in my particular work... I have enough time resource and I have enough independence and autonomy that I can fit in times to be quite reflective, quite reflexively... available to people and I think that's really important (Participant D).*

Another participant expressed that feeling that they were accepted and appreciated for providing supervision gave them the motivation to carry on:

*I feel trusted which is again important to me. I feel valued which is also important and I think that the Health Board is trying its very best to ensure safe practice and trying to encourage people to become clinical supervisors (Participant K).*

## **5.6 Conclusion**

Four themes were identified; acquiring and maintaining the ‘nuts and bolts’ of clinical supervision, practicing flexibly with supervision frameworks, integrating clinical supervision and nursing practice and working within organisational frameworks. Personal attributes, pre-existing skills, supportive factors and training in the theory and practice of clinical supervision were considered important in the provision of clinical supervision. Participants identified that there is a close link between clinical supervision and mental health nursing practice. The findings also highlighted factors that helped participants to provide supervision well as well as some organisational constraints. The next chapter will discuss the findings in relation to national and international literature as well as recommendations and suggestions raised by participants in the study.

## **CHAPTER SIX: DISCUSSION AND CONCLUSION**

### **6.1 Introduction**

The need to ensure competent practice, staff support and to reduce clinical risk in mental health nursing has seen the emergence of clinical supervision policies. These policies have been recommended within health policy and supported by nursing professional bodies. Furthermore DHBs and NGOs have taken up these recommendations and made financial and human resource investments to implement clinical supervision. The need for systems that support nurses to take on the role and to function effectively as clinical supervisors cannot be over emphasised. However, there is a paucity of information regarding clinical supervisors in DHBs. This means that clinical supervision policies have been implemented based on assumptions rather than on evidence. The risk of implementing policies that are not backed by research poses risks of organisations relying on assumptions and therefore not knowing whether clinical supervision is actually effective or not. Lack of information has financial implications and it also means that DHBs are not able to produce clinical supervision policies that are relevant to the needs of practitioners.

While the New Zealand government, regulatory and professional bodies and employers have identified and endorsed the need for clinical supervision, it is the supervisors who step up to fulfil this requirement. It is the supervisors' knowledge, experience and personal attributes that are central to successful outcomes in clinical supervision (Ogren, 2001). Supervisors take on accountability and responsibility roles to the organization, the supervisee and the service user. They are responsible for facilitating learning and they contribute to better understanding of the supervisees' work (Severinsson & Hallberg, 1996a).

This study made it possible for clinical supervisors to describe their experiences of providing clinical supervision in a mental health and addictions service. The aim of the study was to explore the experiences of mental health and addictions nurses who provide clinical supervision in a New Zealand DHB in order that policy-makers, service managers and nurses will be better informed when creating systems for implementation and support of clinical supervision.

This study has found that clinical supervisors were committed professionals whose experience of supervision was rewarding and challenging. Rewards were in the supervisors'

contributions to the development of others and to their own practice. The challenges lay in the need to balance organisational constraints with supervisee needs. To successfully fulfil their role the supervisors used a flexible approach to implement supervision frameworks and were resourceful in relation to organisational constraints. Supervisors found that the processes of clinical supervision and nursing practice were interlinked. Their clinical practice informed their supervisory practice. Likewise, the process of supervising acted as a developmental tool for clinical supervisors who brought new knowledge and reflections back into their own clinical practice.

This chapter discusses the relevance of the findings in relation to national and international literature on clinical supervision. The first section discusses the findings of the study under the major themes: acquiring and maintaining the ‘nuts and bolts’ of clinical supervision; practicing flexibility within supervision frameworks; integrating clinical supervision with nursing practice and working within organisational frameworks. The second section concludes the chapter and outlines the limitations of the study, implications for practice within mental health nursing and provides some recommendations for further research.

## **6.2 Acquiring and maintaining the ‘nuts and bolts’ of clinical supervision**

All the participants in the study agreed that obtaining supervision skills and knowledge enabled them to carry out clinical supervision competently. The acquisition of these skills and knowledge was strongly influenced by their own personal commitment to give back to the nursing profession and by organisational and political factors. Acquiring clinical supervision skills involved the participants obtaining initial supervision training, continuing to up-skill and getting own supervision.

### ***6.2.1 Motivation to supervise***

In this study participants were motivated by their own personal commitment and by organisational imperatives of clinical governance. The commitment of the participants indicated that there was a strong sense of personal drive and willingness to contribute to the growth of the profession via the provision of clinical supervision. There is limited empirical evidence in nursing literature to show that personal factors influence decisions to become clinical supervisors (Lyth, 2000). Available literature provides limited support for the role of



personal factors in decisions to supervise. Bond and Holland (1998a) state that policy directives and concerns about accountability and risk management have become more dominant motives for clinical supervision rather than for good nursing practices and practitioner competence. Findings in the present study indicate that personal motivation is an important factor in clinical supervision.

In addition to personal commitment participants in this study were asked to train and to provide clinical supervision by the organisation as part of a need to fulfil a clinical governance agenda. For some participants, for example, providing clinical supervision was part of their professional roles as educators. Walsh et al. (2003) assert that the use of clinical supervision as part of clinical governance is increasing because of the emphasis on risk management and quality improvement. The Health Practitioners Competence Assurance Act (2003) reflects the importance of supervisors' commitment to clinical supervision. Butterworth, Bell, Jackson and Pajnkihar (2008) note that due to the need to maintain standards of practice and training of nurses, healthcare services now incorporate clinical supervision into clinical governance. For participants in this study, it was important that the provision of clinical supervision ensured quality care, protection of the public and improvement of services to the clients. Consistent with this finding, the Royal College of Nursing (RCN) (1998, cited in Mitchell, 2001) state that "clinical governance will be about improving patient care by allowing nurses to build upon their skills and taking accountability for maintaining and improving standards of care" (p. 242). The findings of this study suggest that it is important for managers who recruit nurses into clinical supervision to recognise that nurses are motivated by personal factors and by an understanding of clinical governance.

### ***6.2.2 Training for supervisors***

Participants in this study found that training in the theory and practice of clinical supervision prepared them with skills to implement it in the organisation and gave them more confidence to take on the roles of clinical supervisor. A number of authors have documented that training and competence in clinical supervision are important. Lynch, Happell, Sharrock and Cross (2008) note that the recognition and acceptance of the potential value of clinical supervision calls for the education and training of nurses in order to make them familiar with clinical supervision. Lyth (2000) notes the need for training of supervisors before embarking on supervising. Training for clinical supervision was also noted as important in a survey of nurses' perceptions of clinical supervision in Northern Ireland (Kelly et al., 2001). A

recommendation from *The Discussion Framework; Mental health and its future*, highlights the need for adequate training for clinical supervisors and cautions that absence of suitable training is detrimental to the success of clinical supervision in that without training, clinical supervision can be punitive and inappropriate (Ministry of Health, 2006).

Participants described supervision training programs that were varied in terms of their structure and content. The courses ranged from two day workshops to year-long part-time courses and the content covered single to multiple models. A survey of clinical supervision approaches and their implementation in New Zealand's mental health and addictions DHBs and NGOs also revealed variation in the use of supervision models and in the way clinical supervision was conducted across the organisations (McKenna et al., 2008). The same survey recommended the setting up of a nationally standardized approach for clinical supervisor training and implementation of clinical supervision. In contrast, participants in the present study were not concerned with standardization. Rather, they valued the opportunity to learn different models and to share ideas.

### ***6.2.3 Maintaining competence to supervise***

Participants in this study acknowledged that even though they had acquired the initial theoretical knowledge and skills to provide clinical supervision, they still needed to continue learning. Loganbill, Hardy and Delworth (1982) note that supervisor development is an ongoing process throughout one's professional career and that each level of development brings greater thoroughness and better outcomes in supervision. Consistent with this view, the participants in this study asserted that by attending supervision updates provided by the organisation, their competence continued to improve from the ongoing professional training. The organisation provided opportunities for on-going development by encouraging supervisors to meet regularly and share their experiences. Supervisor competence influences outcomes for a large number of supervisees and in turn supervisee development and clinical competence affects outcomes for a large number of clients (Severinsson, 2001). This finding also fits in with the requirement by licensing bodies that ongoing continuing education is required for mental health professionals and that includes those clinicians providing and receiving clinical supervision (HPCAA, 2003). By attending updates supervisors were maintaining competence. They were also able to comply with the requirements of the HPCAA.

Participants found some aspects of the supervisor updates to be unhelpful. These related to how the update sessions were organised and conducted. Participants preferred interactive learning that would enable them to learn from each other's knowledge and experiences. This is consistent with Hancox et al. (2004) whose study concluded that role plays, video and group discussions were valuable learning tools. This finding supports the need for organisations to assess the needs of their supervisors and provide relevant ongoing training.

#### ***6.2.4 Own supervision and support***

Receiving supervision regularly encouraged a process through which participants reflected on their practice. By engaging in their own supervision, participants in this study were able to receive support and feedback around their role as supervisors. Supervision can enhance competence by being educative and supportive to supervisors (Severinsson & Hallberg, 1996a). Participants' engagement in self-reflection and receiving feedback about their work enhances development and improves skills required to provide effective supervision (Majcher & Daniluk, 2009). Farrington (1995a) states that supervisors require supervision and support to enable them to maintain their sense of purpose as they go about giving supervision. He maintains that a supervisor "is not all-seeing and all-knowing, is not omnipotent and omnipresent and does not possess deity-like qualities" (p. 875).

Participants in this study did not consider themselves to possess all the knowledge they needed. They regarded receiving supervision as professional development as well as a supportive mechanism that challenged their practice. The finding would indicate that DHBs and other employing agencies need to ensure that proper support and supervision are available for supervisors.

#### **6.3 Practising flexibly within supervision frameworks**

Participants were guided by supervision frameworks in laying the groundwork for supervisory relationships, in sharing supervision responsibilities, discussion of clinical issues, and in adopting flexible approaches to meet supervisee needs. Flexibility in clinical supervision was referred to by participants as actions they took in order to meet diverse needs of those who received it. They carefully used supervision frameworks to ensure that they met their supervisees' needs in a flexible manner. Literature on the practice of clinical supervision

indicates the extent to which diverse and flexible methods are employed. Milne and Oliver (2000) provided a comprehensive list of flexible methods of clinical supervision that include styles of supervision, roles of supervisors, focus of supervision, formats of supervisory arrangements and techniques of the specific interventions that supervisors use.

### ***6.3.1 Laying the foundations of the supervisory relationship***

Participants identified the importance of strong foundations for building and maintaining supervisory relationships. The working alliance between the supervisor and supervisee was regarded as key to effective clinical supervision. Participants identified that building supervisory relationships involved establishing first and foremost, some degree of compatibility and entering into contractual relationships between supervisors and supervisees. Viney, Jukes and Aldridge (2006) refer to a similar process and state that contracting involves establishment of ground rules, boundaries, accountability issues, mutual expectations and an agreement on the working relationship. According to Cottrell (2002) contracting is an important mutual dialogue that involves “clarifying each other’s expectations, motivations, roles and working relationships” (p. 671).

Maintaining the supervisory relationship for participants in this study involved observing boundaries and responsibilities in clinical supervision and meeting the needs of individual supervisees. It also involved creating environments that were conducive and supportive to learning and development. A conducive climate enables the supervisor to provide consistent, reliable and genuine support (Geller & Foley, 2009). The interchange of information between the supervisor and supervisee throughout the supervisory relationship is a developmental process that supports growth and change for both supervisors and supervisees (Severinsson, 2001). Bordin (1983) states that the power for change that occurs in clinical supervision is depended on “the strength of the alliance between the person seeking change and the change agent and the power of the mutual understanding of goals and tasks that are incorporated into the alliance” (p. 35). Sterner (2009) investigated supervisee perceptions of the quality of supervisory relationship and found that supervisees who were more satisfied with their supervisory relationship were more satisfied with their work. A recent New Zealand study investigated the impact of clinical supervision on mental health nurses’ relationship with consumers. In that study, Mernick (2009) found that the nature of supervisory space within supervisory relationships and the use of structured self-reflection

were vital to the supervisory processes which allows supervisees to gain new insights in their thoughts, feelings and behaviour.

Findings of the present study support the suggestion that solid foundations are important to enable supervisees to discover new insights about their nursing practice. This aspect of supervision should therefore be emphasised within training and support for supervisors.

### ***6.3.2 Sharing responsibilities***

Participants in this study noted that although they have certain responsibilities as supervisors, clinical supervision is a shared responsibility between supervisors and the supervisees. Participants identified that during supervision the following are shared responsibilities; preparing for supervision, educating each other about clinical supervision, not doing work for the supervisee, deciding who takes the lead, facilitating reflection, validating practice and knowledge and information sharing. The four latter responsibilities will be discussed in more detail. Both supervisors and supervisees are obliged to share the responsibility of the supervision process (Farkas-Cameron, 1995). Sharing in supervisory relationships allows people to be open to each other and sharing time is indicative of the caring component that is found within supervisory relationships (Beck, 2001; Severinsson, 2001). Supervisors are responsible for exercising their authority and for sharing the focus of supervision and knowledge (Berggren & Severinsson, 2003; Severinsson, 2001). The implication of this finding is that supervision should not be considered a hierarchical process but rather a mutually beneficial relationship in which supervisor and supervisee share responsibility.

#### *Deciding who leads during clinical supervision*

The findings in this study indicated that decision on the topics for discussion and who initiates discussion was a two-way process and that the decisions were dependent on the focus of the sessions, experiences of supervisees and on supervisors' theoretical approaches. This finding is consistent with the writings of Pearson (2001) who suggested that decision making is a fluid process that can change within a session or from session to session.

In this study, participants who supervise groups found that they not only needed skills in supervision but also group facilitating skills. This enabled them to be able to consider and carefully maintain a focus on issues that catered for the whole group rather than for one person. According to literature on forms of clinical supervision, supervisors of groups choose

models that provide a sense of control for the supervisor and safety for the group. It could be argued that the structure of group supervision challenges supervisors' ability to prioritise and make decisions about the focus of particular sessions. This decision making process used in group supervision described by Ofstad (1961, as cited in Berggren et al., 2005) involves the supervisor's abilities to use knowledge and logic to determine the strategy to use.

This finding suggests that the decision on when to take the lead in supervision is not a simple matter. It is influenced by a number of factors including whether the supervision is one-to-one or group. A supervisor uses their judgement when deciding to take a lead during supervision. The complexities of this decision-making could usefully be addressed in supervision training.

#### *Facilitating reflection*

The results of this study indicate that supervisors facilitated reflection to enhance the growth of the supervisees for better client outcomes. Reflection was achieved through the dialogue that occurred as the supervisors facilitated participation from the supervisees and as they challenged and confirmed supervisees' perceptions. According to Dimond (1998 a), it is clinical supervisors who assist with reflection on care. Gonge and Buus (2010) also assert that facilitating reflective processes is a main component of supervision. Walsh et al. (2003) support that reflection on action in mental health practice improves clinical practice. According to Butterworth et al. (1997) learning through reflection occurs when the supervisors help supervisees to illuminate existing beliefs in order to change and deepen understanding of practice issues that lead to more effective interventions. Reflective practice facilitates learning through reflecting on experiences of practice in order to understand and resolve issues that occur between desired outcomes and actual practice (Arvidsson & Fridlund, 2005). It enables practitioners "to explore clinical practice experiences without discounting the possibility that personal values, assumptions and beliefs have influenced both the practice itself and the way that practice is experienced" (Taylor & Harrison, 2010, p. 288). This finding supports earlier research that indicates that supervision is an important tool to assist nurses to reflect on their practice. Such reflection is important for the development of mental health nursing and to enhance the quality of client care.

### *Validating practice and experiences*

Validation or confirming of practices, anxieties, conflicts, potential and achievements was seen as important by study participants in helping supervisees to gain more awareness of themselves. This finding mirrors those of a study to investigate nurse supervisors' views of their supervisory styles, personal qualities and leadership roles in which supervisors stated that they validated supervisees' guilt, irritation and failures (Severinsson & Hallberg, 1996a). These authors described validation and confirmation as the most important aspect of supervisory relationships and that "confirming is to validate the supervisees' experiences as human beings" (p. 160). Severinsson (2001) described validation as a process that is aimed at removing doubt about experiences of reality and at encouraging motivation to carry on even when things have gone wrong.

According to this study's participants validation is cathartic for the supervisees; for they leave supervision knowing that they have been 'heard and feeling that they have been restored'. This finding confirms the importance of supervisees' experiences and humanity. Effective supervision cannot merely focus on cognitive aspects of practice and knowledge.

### *Providing knowledge and information*

Participants reported that they are a resource and they shared knowledge in order to help supervisees grow in their practice. They provided information and literature to supervisees and sometimes about mental health nursing strategies and nursing interventions. Some of the supervisors in the study were educators who were required to provide clinical supervision. This meant that their roles as educators and supervisors interfaced. It can be argued that teaching can occur in clinical supervision because the educative or formative aspect of Proctor's model is in itself a form of teaching (White et al., 1998). Furthermore, Driscoll (2007) describes a cognitive therapy supervision model that involves the supervisee in seeking education and the supervisor in providing guidance resulting in the supervisee developing skills in therapeutic competence. However, Schamess (2006) cautions that teaching in clinical supervision can be tedious and can be viewed as intrusive, critical and humiliating. He favours supervision that stimulates professional and personal growth.

The study findings suggest that these issues of education and knowledge sharing in supervision need further exploration. Although it is clearly a function of supervision, the boundaries of the supervisor and educator roles need further clarification.

## **6.4 Focusing on clinical issues**

Clinical supervisors in this study believed that it was important to focus on clinical issues and that they were reluctant to dwell on organisational and personal issues. The participants sometimes felt that issues that were brought to clinical supervision were not clinically focused. They struggled to separate clinical from non-clinical issues because of their interface with personal and management issues. While some of the participants stayed away from discussing non-clinical issues, others explored the issues further to ascertain their links to client care and referred supervisees to appropriate services such counselling. Jones (1998) emphasises that clinical supervision is not a management tool or therapy and cautions that it was at risk of exploitation. Lyth (2000) points out that clinical supervision should be a developmental rather than a punitive process and offers two different options for the focus of clinical supervision. Firstly, clinical supervision should focus on both nurse and client with emphasis on personal growth while the second option is that clinical supervision is about client related clinical issues. Lyth argues that the diversity of the benefits of clinical supervision namely improved client care, increased self-awareness, knowledge and skills, reduction in stress and burnout, reduction in complaints have implications for clients, practitioners as well as organisations.

This finding suggests the importance of supervisor's clarity around the focus of clinical supervision. For these participants, the client-centred focus allowed them to feel that supervision was on-task.

## **6.5 Adopting a flexible approach**

### ***6.5.1 Flexible use of models***

Participants in the study used different models to provide clinical supervision. Literature on the process of supervision states that supervisors use different models and styles to implement supervision (Severinsson, 1996). For some participants in the study, decisions to adopt certain approaches were based on the models the supervisors knew from their own supervision training. For others, the decision was influenced by the needs of the supervisees in relation to the focus of the sessions as well as the developmental level of the supervisor and supervisee. Participants pointed out that over time as they gained more experience in supervising; they developed more flexible approaches in the use of supervision models. Most



participants were trained in the TAPES model. Other participants used Proctor's (1986) three function model and found that its formative (educational), restorative (supporting) and normative (qualitative aspect of practice) could be adapted in a fluid fashion within single or group sessions. According to Lyth (2000) there are a large number of models and supervisors can choose and use models that are most relevant to the needs of the supervisee at the time. Some participants in this study elected not to use any model, preferring to take the supervisee's lead on any particular day. The variability in the use of models is also reflected in the literature on approaches used in clinical supervision in New Zealand's mental health and addictions services (McKenna et al., 2008; Ministry of Health, 2006; Te Pou, 2010).

The finding in this study suggests that no one model of supervision fits all and that models need to be tailored to suit individual needs. Reliance on providing training in only one model nationally could reduce the range of skills and interventions to nurse supervisors.

#### ***6.5.2 Responding to supervisees' levels of experience***

The developmental level and work experiences of supervisees influenced decision making in the supervision process in this study. The supervisees' level in their careers impacted on the way they understood clinical supervision and their expectations of it. Respondents reported that junior practitioners had distinct needs from those who have been in the field for longer periods. The participants therefore tailored clinical supervision to suit the different needs of supervisees. According to Pearson (2001) the developmental level of practitioners determines dependence on the supervisor versus autonomous function. Acknowledging the different levels helps supervisors to make decisions regarding the balance of supportive versus challenging interventions needed; the degree of structure provided; the amount of teaching, skill development, and direct suggestions needed; and the degree to which personal reactions are explored (Stoltenberg, McNeill, & Delworth, 1998). This finding confirms that supervisors employ appropriate supervision styles to suit supervisees' levels of learning and experience.

### **6.6 Integrating clinical supervision and nursing practice**

In this study, there was an interconnection between clinical supervision and nursing practice of the participants. Supervisors transferred their attributes, skills and knowledge into their supervision roles and found that they also developed in their own clinical practice through

providing supervision. During the course of data collection participants disclosed that the process had allowed them to reflect more on their role as supervisors and that the discussions had allowed them opportunities to contribute information and to identify and develop stronger and trusting relationships with other supervisors and supervisees.

#### ***6.6.1 Building on personal and professional attributes***

In addition to knowledge, skills and personal commitment, participants described other attributes that contribute to their abilities to provide supervision. Participants described themselves as being people persons with abilities to listen effectively, clarify issues, not pass judgements, persevere with supervision, friendly and inquisitive. Bulmer (1997) highlighted similar attributes for supervisors in this study. Other authors have identified interpersonal and good communication skills as important supervisor attributes (Pesut & Williams, 1990; Sloan, 2005). A study to identify the characteristics of a good supervisor found that the ability to form supportive relationships and possession of knowledge and clinical skills were important attributes of a good supervisor (Sloan, 1999). The findings from these studies indicate that personal qualities, interpersonal competence and knowledge are considered important attributes of a good supervisor. These attributes are also important for mental health nurses.

#### ***6.6.2 Developing own nursing practice***

The experience of providing clinical supervision allowed participants to develop in their own personal and professional capacities. Participants described direct involvement in clinical supervision as instrumental to their own growth and development. Repeated practice enabled them to gain more confidence and expertise. In addition participants mentioned that this was a 'vicarious experience' where they were exposed to other people's wisdom. According to Arbon (2004) vicarious experience occurs when nurses use scenarios, listen to other people's accounts and observe actions in order to develop. Furthermore Cleary and Freeman's (2005) study considered it important for experienced staff to provide less experienced staff with education, support and opportunities to evaluate their practice and interpersonal relationships and that by doing so, the more experienced staff were exposed to new thinking and to modern nursing practices.

While this finding is not strongly supported by existing literature, it is significant. Since clinical supervision provides support not only for the supervisee but also for the

supervisor, it is in the interest of the services to support nurses to provide supervision. In doing so, the service and the clients are doubly-benefitted.

### ***6.6.3 Clinical supervision and its link to other clinical and professional skills***

While clinical supervision is noted to be a specific skill, participants in this study highlighted its link to mental health nursing practice and to their other professional roles. This appears reasonable since there is a strong correlation between clinical supervision and other psychotherapeutic approaches. Yegdich and Cushing (1998) assert that nursing clinical supervision has its origins in psychoanalytic theory, social work and counselling. Participants in this study felt that the skills and practice of clinical supervision are a continuation of mental health nursing practice and they believed that skills learnt in nursing training were transferable to clinical supervision and vice versa. According to Burrow (1995) clinical supervision is not a new concept to mental health nursing. Puanonen (1991) and Jones (1998) concurred that clinical supervision is not a new concept in mental health nursing. White et al. (1998) conducted a study of the experiences of supervisors and supervisees around the domains of structure, process and outcomes in clinical supervision. Findings indicated that the concept of clinical supervision was regarded as similar to and often confused with mentorship, preceptorship, and counselling. Clinical supervision was linked with individual performance reviews, personal therapy and management. Although the issues are not the same in these study findings White et al's findings support the interrelatedness of the skills used in nursing and in clinical supervision.

In the study participants called on cognitive behaviour therapy (CBT), dialectical behaviour therapy (DBT), group facilitation and counselling skills to support supervisees as they attempted to maintain effective therapeutic relationships in their practice. Similarities have also been drawn between cognitive behaviour therapy and clinical supervision in that both approaches are structured, educative and they focus on competence and skills acquisition (Townend, 2005). A study that developed a cognitive behavioural model of clinical supervision for use by mental health nurses supports the experiences of participants in the present study in that the use of alternative professional frameworks is essential within the reflective learning and development environment of clinical supervision (Townend, 2008).

This finding suggests that mental health nurses can and do draw on their skills in various therapeutic modalities when providing clinical supervision. This phenomenon could be used to enhance the training of mental health and addiction nurse supervisors.

## **6.7 Working within organisational frameworks**

Participants in the present study believed that the organisation influenced the outcomes of clinical supervision. They reported that while the policies and frameworks of clinical supervision were designed to guide best practice and therefore could be supportive, some policies constrained the implementation of clinical supervision. Although the service supported a policy of mandatory supervision for all nurses, systems and resources did not provide sufficient support to allow this to occur. Policies concerning clinical governance were also sometimes at odds with requirements of clinical supervision. Despite these limitations, the respondents identified ways of working within these frameworks and to balance the needs of the supervisee against policies. This discussion will address the organisational frameworks and constraints that are most significant for mental health and addictions nurses and in other areas of practice.

### ***6.7.1 Mandated clinical supervision***

While the clinical supervision policy required all mental health and addictions nurses to engage in supervision, participants believed that the policy was loosely applied as not all nurses were receiving supervision. Literature on whether clinical supervision should be mandatory is unclear. New Zealand professional and regulatory bodies recommend that nurses engage in clinical supervision as a way to ensure competency to practice but they are unclear about whether the practice should be mandatory or not (Nursing Council of New Zealand, 2007; Te Ao Maramatanga: New Zealand College of Mental Health Nursing, 2004). The Nursing and Midwifery Council (2007, cited in Sloan, 2008) does not require mandatory clinical supervision for nurses nor does it make clinical supervision a requirement for registration. Gray (2001) suggests that prohibitive costs of providing and paying for clinical supervision is one reason why organisations are reluctant to make it mandatory. Cleary and Freeman (2005) argue that the culture of support and guidance as well as informal processes such as handovers and case reviews reduce the need for compulsory clinical supervision.

Participants in this study emphasised that clinical supervision was important and recommended that it would be more effective if it was practised by all mental health staff rather than by a small group of people. They suggested supervision be made compulsory and that it be introduced to staff at recruitment level. These findings support the call for organisations to be more transparent about their support of supervision. If supervision is to become a central aspect of nurses' support and development, appropriate funding must be made available to allow all nurses to access supervision.

### ***6.7.2 Negotiating managerial concerns and policies***

#### *Involvement of management in clinical supervision*

The involvement of management in clinical supervision was frequently commented upon by participants in this study. Although it was not a regular requirement, supervisors were at times required to report the content of supervision to managers. This placed participants in awkward positions and was perceived to hinder the supportive and developmental functions of clinical supervision. Participants took care to ensure that the contractual process highlighted that only issues of an ethical and safety nature would be shared with management. Literature suggest that dealing with the complexity surrounding managerial and clinical agendas depends on the supervisors' training experience and ability to separate them whilst acknowledging the normative aspect of clinical supervision can be a part of the goals of the organisations (Scanlon & Weir, 1997).

This finding indicates the complexity between managerial issues of quality control, accountability, clinical audits and professional issues of confidentiality and competency.

#### *Documentation in clinical supervision*

In the present study participants were obliged by the organisation's clinical policies to document clinical supervision activities but the findings indicated variability in the way clinical supervision was documented. The findings indicate that participants were uneasy about the potential ethical and legal implications arising from supervision records because of a requirement to submit the records to the organisation. They felt that this requirement was a breach of confidentiality which could result in supervisees not sharing or disclosing any information that had the potential of questioning their conduct. Weiner and Wettstein (1993, cited in Falvey & Cohen, 2003 ) cautioned that over-documenting or under-documenting has potential legal and ethical pitfalls. Powers (1999) suggested writing brief pertinent

information relating to the content and organization of the supervision while Johns (1996) recommends that the supervisor keeps records in order to highlight key issues that can be revisited in future. Cutcliffe (2000) suggests that supervisors and supervisee need to negotiate methods of documentation that suit them. None of the aforementioned authors addressed the boundary between supervision and performance management.

Participants in the study acknowledged the need to document their sessions, but they devised ways of keeping records in a manner that was considered efficient and safe. This issue has been discussed in a subsequent review of supervision policies in the DHB.

*Managerial concerns extended to the issue of supervising colleagues or subordinates*

Participants felt that they could not supervise people who worked within the same team as their own. All but one participant indicated that they could not supervise their subordinates. Reasons given were that doing so was a violation of professional and ethical boundaries. Participants in this study emphasised that the proximity of supervising one's team mates can cloud objectivity and what some participants called 'naive questioning'. Literature on the issue of managers also acting as supervisors highlights conflict and confusion that can occur. A study by Cutcliffe and Hyrkas (2006) found that clinicians felt that combining clinical supervision with management supervision "... inevitably severely diminishes the more democratic, emancipatory, supportive and developmental aspects of clinical supervision" (p. 625). Similar results were highlighted in a study that explored the complexities that arise from the interface between managerial and clinical supervision among mental health nurse supervisors and their managers (Kelly et al., 2001). Cutcliffe (2003, cited in Cutcliffe and Hyrkas, 2006 ) highlighted that the dual roles of supervising and managing tends to focus on management and performance issues as the main agenda instead of reflective and professional development issues of supervisees. There is also the danger of confidential information being used for disciplinary purposes by the managers.

One participant believed that linking clinical supervision to management is effective in terms of time and resources and that it facilitates a continuous chain of communication between clients, practitioners and managers. Consistent with this view is an audit of literature that indicated that the dual role of manager and supervisor increases an understanding of the link between issues raised in clinical supervision and the roles and responsibilities of the supervisee (Barriball et al., 2004). According to Cutcliffe and Hyrkas (2006) management

involvement helps with supporting, facilitating and evaluating clinical supervision as well ensuring professional accountability. The study's findings suggest that managerial and supervisory functions are different but overlapping. It is important that organisations and clinical staff members are clear about the expectations and boundaries surrounding the two functions.

### **6.8 Organisational constraints**

Despite the service's stated commitment to providing clinical supervision for all staff, the participants in this study reported that organisational constraints limited their ability to fully action such policies. Their ability to provide clinical supervision was constrained by three factors. First, the limited availability of trained supervisors; second, unclear processes of linking potential supervisors and supervisees; and third, environmental factors that interfered with nurses' ability to attend supervision sessions.

The shortage of clinical supervisors in this study was considered to impact negatively on the overall practice of supervision. This concurs with the findings of Kelly, Long and McKenna (2001) who reported that shortage of clinical supervisors in Ireland affected the abilities of mental health nurses to problem solve, improve practice and to understanding of professional issues. In another study, shortage of trained clinical supervisors was identified as a hindrance in the development, implementation and expansion of clinical supervision (Barriball et al., 2004). These authors recommend that priority be given to clinical supervision including allocation of specific resources for supervisor and supervisee training. Waskett (2010) recommends a training model involving joint compulsory training courses for supervisors and supervisees as one way to ensure that clinical supervision is accessed by all clinical staff. Mullarkey, Keeley and Playle (2001) suggest that multi-professional clinical supervision can help alleviate the problem of staff shortages. They argue that the nature of mental health nursing places nurses in closer alliances with practitioners from other professions and that multi-professional clinical supervision "may enhance learning between different professionals, leading to a greater understanding of the specific contributions that individuals from different professions can make to client care" (p. 207).

In this study, the supervisors revealed that facilitating the sharing of clinical, organisational, developmental and emotional experiences in group supervision is demanding.

Supervising groups was a constraint associated with inadequate training and human resource shortages. Participants in certain senior roles were required to provide supervision to groups but they have not received adequate training to specifically work with groups. Literature on group supervision states that while group supervision encourages sharing and increases confidence, it is demanding because supervisors need to possess clinical supervision skills as well as skills in group dynamics (Hyrkas et al., 2002). Supervising groups also required flexibility on the part of the supervisor in which the supervisor strove to meet the needs of the group members. According to Proctor (2000) the supervisor adopts different roles to accommodate the events and changes that occur amongst group members.

Supervisors in this study used other group facilitation skills such as those used to run dialectical behaviour therapy (DBT) and cognitive behaviour therapy (CBT) groups to facilitate group discussions. It was left to the individual supervisors to develop the skills to manage group facilitation.

Another constraint identified by participants was the problem of irregular attendance by group members. The number of supervisees who attended clinical supervision ranged between one and nine at a time due to sickness, leave, long distances from workplaces, shift work and high work-loads that made it difficult for supervisees to leave their workplaces. This made continuity and trust building difficult among group members. Similar findings were reported by Buus, Angel, Traynor and Gonge (2010) who stated that variations in group sizes due to shift-work meant that groups were continuously ‘forming’ as new members joined the group while older members left. This affected interpersonal relationships and made self-disclosure difficult. The findings of the present study suggest that innovative models of training and support for clinical supervisors need to be implemented in order to develop a sustainable system of clinical supervision for mental health nurses in New Zealand DHBs.

Participants highlighted that the process of identifying available and suitable supervisors within the organisation is unclear for both supervisors and supervisees. Similar findings were reported in an audit of clinical supervision within a primary care facility (Barriball et al., 2004). Outdated databases raised problems of new supervisors being unidentifiable while existing supervisors were overloaded. These authors suggested that an up to date central database be created in order to facilitate a more efficient selection process. Participants in this study made a similar recommendation, suggesting the development of a



webpage on which supervisor availability and background information about supervisors' skills and experiences could be posted.

Participants felt that clinical supervision was not afforded priority in the work place and that clinical supervision often got cancelled in favour of other activities. Barriball, While and Munch (2004) concur with this finding when they reported that high workloads and time constraints meant that both supervisors and supervisees often cancelled clinical supervision. Their view was that succumbing to workloads and time constraints undervalued the importance of clinical supervision and made clinical supervision "an optional extra which staff could easily opt out of if desired" (p. 393). Findings from earlier studies indicated the influence that workloads, staff shortages and service reorganizations has on attendances (Gilmore, 2001).

Findings in the present study also showed variability in attendance between community and inpatient practitioners and between trained and untrained staff. Community nurses attended clinical supervision more often than their inpatient counterparts while registered staff attended more often than untrained staff. A survey and longitudinal study of psychiatric nurses' participation in clinical supervision conducted in Denmark by Gonge & Buus (2010) revealed similar results. The results revealed that participation in clinical supervision was influenced by organizational factors, type of work, workplace location and shift work. Untrained staff participated less than registered nurses and community nurses participated more than in-patient staff. Shift work also impacted on attendances with less participation from staff who worked evening and night shifts compared to those who worked on day shifts.

A lack of appropriate venues also constrains clinical supervision practices. While participants in this study pointed out that privacy and confidentiality were important factors, they struggled to find venues that offered them this. Most venues were either too far from the workplaces, too close, too noisy or difficult to access due to security reasons. Similar findings were reported in a study to identify the factors that influence the effectiveness of clinical supervision in community mental health nurses. The study concluded that supervision that is conducted away from the workplace improved rapport and trust and those supervisees felt more comfortable to discuss confidential issues (Edwards et al., 2005). Where clinical supervision was held within the workplace participants were always on edge in case they got

called back to work and they often got interrupted. Gilmore (2001) pointed out that lack of suitable accommodation or being too close to the working areas increased the possibility of getting interrupted.

Although this present study has not provided solutions to the problem of nurses' attendance at supervision sessions and the availability of appropriate venues, it has reinforced the issue as a problem that needs to be addressed. It is clear that nurses in some settings face much greater barriers than others when they attempt to set up regular supervision. This needs to be recognised when supervision systems are established.

### **6.9 Benefitting from organisational supports**

Participants reported that they felt most supported when the organisation recognised them as responsible practitioners who could make independent decisions about how they provided supervision. Participants exercised autonomy by drawing on their knowledge and experiences while also working within clinical supervision frameworks and the policies of their organisation. In line with the notion of extended practice in nursing, providing clinical supervision places a greater responsibility for decision-making and accountability on supervisors who are themselves practising supervision in isolation. According to Berggren and Severinsson (2003) clinical supervisors apply the principle of autonomy in their leadership roles as they have the authority and responsibility for making decisions that can affect client outcomes. They are role models who are also responsible for encouraging their supervisees to also be autonomous practitioners. With autonomy, comes the responsibility of self-management. In this study, participants exercised autonomy with regards to limiting the number of supervisees they could work with. Literature highlights the supervisors' need to maintain control of their workloads and to be able to decline requests for supervision that is beyond their capacity in terms of time or experience (Waskett, 2010).

Autonomy had its down-side for supervisors working in isolated and rural areas. These participants had either no or limited access to colleagues or other supervisors with whom to exchange ideas and discuss concerns. This was made worse if participants felt unheard or unsupported by their managers and when they could not access their own supervision.

Clinical supervision is a role that extends the practice of experienced mental health and addiction nurses. If the role is to be satisfying, organisations need to recognise the

nurses' expertise and support them to practice autonomously. This is a particular challenge for nurses in isolated areas where autonomy must be balanced with adequate support.

This section of the chapter has discussed the study findings in relation to local and international literature. Acquiring and maintaining the 'nuts and bolts' of clinical supervision was reported as fundamental in recognising clinical supervisors as a skilled workforce who possessed skills and knowledge required to provide clinical supervision. Supervisors then shared supervisory journeys with supervisees and negotiated their way through supervision frameworks and organisational constraints to develop supervisees' and their own practice. The next section concludes the chapter by highlighting the limitations of the study and makes recommendations for research, nursing practice and policy-making.

## **6.10 Conclusion**

The purpose of this study was to explore the experiences of nurses who provide clinical supervision in a New Zealand DHB mental health and addictions service. The motivation to undertake this research came from my own experiences as a supervisor. I had many questions around how other supervisors experienced their roles, what they did and why they did it. At that time there were not many studies that had used mental health nurse supervisors as respondents in New Zealand DHBs. Exploring the experiences of clinical supervisors was important in order to illuminate the processes and support systems surrounding clinical supervision. The risk of not knowing if supervision was working has financial and clinical implications for DHBs. Therefore the findings of this study can help to guide supervision policy and aid professional support for nurses. The timing of the study coincided with a review of local and international literature on the approaches of clinical supervision in mental health and addictions services and with a pilot study on the implementation of clinical supervision in New Zealand (McKenna et al., 2008; Te Pou, 2010). The findings of the present study will contribute and add to existing literature on clinical supervision in New Zealand and internationally. The experiences of supervisors in this study will complement the findings made by (McKenna et al., 2008; Te Pou, 2010). Other DHBs and NGOs can use the findings as a basis for implementing clinical supervision in their own settings.

A qualitative descriptive method was employed in this study. Data was collected from a purposive sample of 15 participants. The data was collected by means of semi-structured

individual interviews. The chosen method allowed participants to express a wide range of issues. A thematic analysis method was used to analyse that data. Some direct quotes were used to highlight the voice of participants in the study.

The language of the participants throughout this study revealed a strong sense of commitment to developing professional competence and growth in mental health nursing. The success of clinical supervision experience was found to depend on four processes supervisors engaged in; acquiring the ‘nuts and bolts’ of clinical supervision; practising flexibility within supervision frameworks; integrating clinical supervision with nursing practice and working within organisational frameworks.

### **6.11 Limitations of the study**

In this study 19 (42%) supervisors responded to an invitation to participate in the study and 15 (33%) met the criteria and participated in the study. While the sample was purposively selected, respondents were motivated volunteers who were interested in contributing their experiences to mental health nursing research. The researcher identified respondents who had knowledge of the research topic and who provided rich information. This could be seen as a low number and therefore not representative. However small purposive samples in qualitative research provide rich contextual information that contributes to existing knowledge (Streubert & Carpenter, 1995).

The qualitative study was conducted in one DHB in New Zealand. The findings present a description of the experiences that are unique to the experiences of nurses in that particular context. This means that the findings of the study are not generalisable and cannot be extended to a wider population. While the findings may not be generalisable, the implications can be used to inform nursing practice and policy making (Finfgeld-Connett, 2010).

The study was conducted at a time when the clinical supervision policy was undergoing review within the DHB. This means that any changes such that were made to the policy do not accurately reflect the experiences that were described by participants during that time.

The demographic make-up of the participants was that all participants were experienced practitioners with over ten years nursing experience and more than three years clinical supervision experience. Their experiences may not be representative of less experienced nurses and clinical supervisors in the DHB.

The data for this study was collected and analysed by the researcher who was also a clinical supervisor and was known to the respondents. Being closely associated with the inquiry and being part of the population meant that bias could not be totally eliminated (Carolan, 2003). This could have affected the responses of the participants and the interpretation of the data by the researcher. During data collection and analysis the researcher consulted with academic supervisors to reduce researcher bias.

All participants in the study provided mainstream clinical supervision and none provided Kaupapa Maori supervision. While the study did not specifically target Maori and Kaupapa Maori supervision, the experiences of supervisors who provided this form of supervision were not captured. The study provided little information around Kaupapa Maori and other experiences of bi-cultural supervision.

## **6.12 Recommendations**

The significance of providing clinical supervision is recognised as important in mental health nursing in that it can enhance staff performance and improve client care (Severinsson & Borgenhammer, 1997). Clinical supervision also improves job satisfaction, enhances integration of theoretical and practical knowledge, increases confidence, self esteem and empathy (Arvidsson et al., 2001) and provides opportunities for education, learning, feedback and validation (Jones, 2003). Recommendations for research, practice and policy-making are discussed below.

### **6.12.1 Research**

- All participants in this study indicated that they received clinical supervision. They provided some insight into its benefits and their experiences as supervisees. A study focusing on supervisees would illuminate the experiences of those who receive clinical supervision.

- Participants in this study were all senior nurses. It is unclear why junior nurses do not participate as supervisors. Experiences of nurses who are less experienced in terms of nursing and clinical supervision experiences needs exploration.
- Further research is indicated on the interplay between supervisor and supervisee professional development. Better understanding on how supervision supports the practice of the supervisor would assist with the planning and implementation of supervision training and practice.
- While this study did not specifically target Maori respondents and Kaupapa Maori supervision, it was noted that none of the participants chose to incorporate cultural supervision in their practice. This is perhaps not surprising since clinical and cultural supervision are generally viewed as distinct processes. Research is needed on how cultural supervision is being implemented amongst nurses in DHBs and on a wider scale. Such research could provide vital information on how well cultural supervision is being supported or implemented. This data can assist in the development of a skilled Maori mental health and addictions workforce who can meet the needs Maori clients. Awareness and understanding of the bicultural nature of nursing and supervision and the impact on client outcomes are important.
- Research into the practice and policy of supervision amongst general nurses and those mental health nurses who work in private practice and NGOs would determine if their experience differs from nurses in this study. Such research would indicate whether support systems should be tailored for nurses practising in different situations.

#### **6.12.2 Practice**

- There is a need to train more clinical supervisors in the theory and practice of clinical supervision. Identification and training of suitable personnel is important in order to make clinical supervision available to all nurses.
- More emphasis needs to be placed on ongoing skill development for clinical supervisors. Consulting with supervisors around suitable methods of learning such as interactive and reflective learning and the inclusion of practical sessions like role

plays and group discussions are recommended as ways of further developing supervision practice.

- While the study did not focus on group clinical supervision, an incidental finding was that some participants provided group supervision to trained and untrained staff in addition to one-to-one supervision but they did not have adequate training for this role. Equipping supervisors with group supervision skills is important.
- Addressing structural and logistical problems can facilitate effective clinical supervision. This requires DHBs to ensure that clinical supervision is continuous and consistent by providing adequate resources and time for practitioners to attend clinical supervision.
- Respondents expressed frustration at the limited knowledge and understanding of clinical supervision that was displayed by supervisees and at times by some managers. While the emphasis to train supervisors cannot be underestimated, supervisees also require training to enable them to understand clinical supervision.

### **6.12.3 Policy**

- There is need for clarity in services around the compulsory nature of clinical supervision. Perhaps the bridge between formal and informal processes of staff support and development require further defining. The notion that clinical supervision has always occurred in nursing needs to be addressed otherwise clinical supervision will not receive value and the priority.
- Inclusion of clinical supervision education in undergraduate nursing programs would equip new nurses with supervision skills in the early stages of their careers. These skills are important for effective participation when receiving and providing supervision.

### **6.13 Summary**

This study has described the experiences of nurse supervisors in a DHB mental health and addictions service. The study has identified that providing clinical supervision is a rewarding as well as a challenging experience. Providing clinical supervision is mostly a positive experience for the nurses who are personally motivated and committed to improve nursing practice. By contributing to the development of others and their own practice, providing clinical supervision has been identified as rewarding while the need to balance organisational policies and constraints with supervisee needs has been found to be challenging. The findings in this study have suggested that despite the challenges of providing supervision in a DHB setting, mental health and addiction nurses are keen and motivated to implement clinical supervision.

The participants' experience highlights the need for a work force that is trained in theoretical knowledge, practical skills and possesses certain personal qualities. This foundation is critical to establish supervisory processes that allow supervisors and supervisees to develop practice. Clinical supervision training and continuous professional development programmes should thus be tailored to meet the needs of the supervisors; ongoing interactive learning and clinical supervision of supervisors are important aspects of such programmes.

Although clinical supervisors in this study acknowledged the need for guidance by frameworks and clear organisational expectations, they described the importance of autonomous practice and the desire to be creative and flexible. Their experience suggests that DHBs and other mental health and addictions services need to have clear supervision policies and procedures that support autonomous practice. The relationship between the organisation, supervisors and supervisees in the development and implementation of clinical supervision policies and guidelines encourages communication and more effective engagement with the supervisory process. Organisations are therefore encouraged to invite nurses who are motivated and committed to supervision. This investment is well worth it as it will bring out the best in supervisors as well as supervisees.

As a mental health nurse as well as a supervisor, I found that by undertaking this study, I have also gained more insight into the world of clinical supervisors and have developed a greater appreciation of the contributions that supervisors give to the nursing profession.



## Appendix A

### SCHOOL OF NURSING

#### Faculty of Medical and Health Sciences

Ecom House  
5<sup>th</sup> Floor 3 Ferncroft St  
Grafton  
Auckland  
Telephone 64 9 373 7599 Ext 87563  
Facsimile 64 9 367 7158

The University of Auckland  
Private Bag 92019  
Auckland Mail Centre 1142  
New Zealand

**Dear.....**

I am a community mental health nurse with the assertive community treatment team in Hamilton. I am also a clinical supervisor.

I am studying for a Master of Nursing degree with Auckland University. I am seeking expressions of interest for your participation in my research. If you are a practicing clinical supervisor, with more than two years experience, please contact me and I will provide you with more detailed information.

If you are unsure and would like more information, please contact me at [removed], phone, 834 6902 or email: [removed].

Sincerely

Emilia Hlatywayo

## Appendix B

### SCHOOL OF NURSING

Faculty of Medical and Health Sciences

Ecom House  
5<sup>th</sup> Floor 3 Ferncroft St  
Grafton  
Auckland  
Telephone 64 9 373 7599 Ext  
87563

Facsimile 64 9 367 7158  
The University of Auckland  
Private Bag 92019  
Auckland Mail Centre 1142  
New Zealand

### Information Sheet for potential participants

#### Study title

**A qualitative descriptive study exploring the experiences of mental health and addictions nurses who provide clinical supervision in a New Zealand District Health Board.**

You are invited to take part in a research study to explore the experiences of mental health nurses who provide clinical supervision within the District Health Board.

#### Researcher

The study will be conducted by Emilia Hlatywayo as part of a Master's Thesis in Nursing. Supervision of the study will be provided by Kate Prebble (PhD) and Anthony O'Brien (M Phil) of the School of Nursing, University of Auckland.

#### Background

Clinical supervision in nursing practice is recommended as one strategy of ensuring public safety, competent practice, ongoing professional development and safe practice. Clinical supervision is seen as a quality improvement strategy which improves outcomes for service users and reduces stress for staff. The Mental Health Nursing and its Future discussion document (Ministry of Health, 2006) and the Nursing Council of New Zealand (2007) recommends the need to strengthen mental health nursing and to maintain competent practice through clinical supervision respectively. Clinical supervision is carried out by practitioners who take on the responsibility to support and facilitate learning and development of fellow nurses in accordance with regulatory, professional and organisational needs.

Research on clinical supervision has tended to focus on findings from the perspectives of supervisees and managers. Unfortunately little is known about the experiences of mental health and addiction nurses who provide clinical supervision.

### **Aim of study**

The aim of the study is to explore and describe the experiences of mental health and addictions nurses who provide clinical supervision in the district health board.

### **Why you have been chosen to participate**

You have been chosen to participate because of your knowledge and experience of clinical supervision. I would like to interview nurses who have had at least two years experience in providing clinical supervision to mental health nursing colleagues within the DHB. For the purposes of this study, I will not include nurse supervisors who are engaged in external supervision. The information you will provide will add richness to that provided by other nurses and will assist me to gain information required to answer the research question. Participation in this study is entirely voluntary. If you decide to participate, you can withdraw at anytime without any need to provide an explanation.

### **Study procedures**

#### **Part one: Individual interviews**

Individual interviews will be held at a private venue of your choice. Each interview will take approximately one hour. To get a full description of your experiences, the interview will take the form of broad questions. You are not obliged to answer all of the questions. To ensure that your information is recorded accurately, the interview will be audio- recorded using a digital voice recorder. You can request for the recording to be turned off at anytime without giving reason. You can withdraw any information collected during the interviews at any time before 31<sup>st</sup> May 2010, before data is analysed. All the information you provide will be confidential.

#### **Part two: Focus groups**

A second meeting will be arranged for the researcher to meet with you and a group of six to nine other nurse supervisors. Your participation in the group is optional. I will facilitate discussion with group members so that you can share your collective experiences. Discussions will take sixty to ninety minutes and will be audio- recorded as with individual interviews. Due to the nature of focus groups recordings of discussions cannot be stopped once started. Once provided, information from focus groups cannot be withdrawn. However, you are not obliged to answer all or any questions asked during the discussions and you can leave the focus group at any time. Due to the nature of discussions in the group, confidentiality of information and identity cannot be guaranteed but you will be asked to

respect each other's confidences. However the researcher and transcriber are obligated to keep all the recorded information confidential.

### Data management and analysis

You will be allocated a pseudonym (an alphabetical letter) to ensure confidentiality of the information you provide. Recorded interviews will be transcribed by a professional transcriber. The transcriber will sign a confidentiality agreement before the interview is recorded. This is to protect your identity and the information you will provide. Before completion of the study, you will be given an opportunity to review the transcripts to verify that your information is recorded accurately. All audio recordings, notes and transcripts will be retained by the researcher and kept in secure separate cabinets. They will be accessed by the researcher and the supervisors only. At completion of the study you may be given back a copy of your interview at your request otherwise the transcripts will be kept and then destroyed six years after completion of the study. The information you provide will be analysed for themes. Some quotes from your interview may be published just as you say them so that your views will be reflected in the final report. However, no individual data that can identify you will be used in the final report or publications.

### Results

Results of this study will be presented as a Masters of Nursing Thesis and possible journal articles. A summary report of the findings will be given to you at your request. A summary report and recommendations will be submitted to the Clinical Nurse Director of Mental Health Nursing and [removed] District Health Board Ethics Committee. Copies of the entire study will be submitted to The University of Auckland and [removed] District Health Board libraries. The study results may be used by other researchers in future. The findings will also be presented to various nurses at mental health nurses forums.

### **Benefits/risks of taking part in the study**

There is no direct benefit to you from taking part in this study. It is anticipated that there are no risks. However should any discomfort arise from the discussions, you could, with your permission be referred to the Employee Assistance Programme for support. The value of the study will be to assist mental health and addictions nurses to reflect on and inform their practice around clinical supervision. The information will assist to provide quality interventions and enhance the outcomes for service users.

Any parking costs that you incur during the study will be reimbursed by the researcher

### **How to respond**

If you would like to participate in the study please sign the consent form and return it by internal mail to **Emilia Hlatywayo, [addresses removed]**

### **Further information**

If you would like further information about the study please contact Emilia Hlatywayo on 07 834 6902 or e-mail me at [removed] you can also contact Dr Kate Prebble (academic supervisor) at 093737599 ext 83413 or e-mail at [k.prebble@auckland.ac.nz](mailto:k.prebble@auckland.ac.nz)

If you have any concerns or queries about the study, you can obtain independent support and advice from the Health and Disability Advocacy Service on 08004ADNET (0800 42 36 38) Monday to Friday 0800 – 1630hours.

For any queries regarding ethical issues, you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Office of the Vice Chancellor, Private Bag 92019, and Auckland 1142. Telephone 09 373 7599 ext 83711.

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 13/08/2009 for 3 years Reference Number 2009/308. Approval has also been obtained from [removed] District Health Board Ethics Committee and [removed] District Health Board Kaumatua Kaunihera Committee.**

## Appendix C

### SCHOOL OF NURSING

Faculty of Medical and Health Sciences

Ecom House  
5<sup>th</sup> Floor 3 Ferncroft St  
Grafton  
Auckland  
Telephone 64 9 373 7599 Ext 87563  
Facsimile 64 9 367 7158

The University of Auckland  
Private Bag 92019  
Auckland Mail Centre 1142  
New Zealand

### PARTICIPANT CONSENT FORM

**(THIS FORM WILL BE HELD FOR A PERIOD OF SIX YEARS)**

**Title of study: A qualitative descriptive study exploring the experiences of mental health and addictions nurses who provide clinical supervision in a New Zealand District Health Board.**

I have read the participant information sheet. I have understood the nature of the study and why I have been selected to take part. I have had the opportunity to ask questions and I am satisfied that my questions have been answered. I understand that I can ask further questions at any time.

I understand that my participation is voluntary.

I can decline to answer any particular questions in the study without giving any reason.

I understand that the interview and focus group discussions will be audio-recorded.

I understand that for personal interview I can request for the interview recording to be turned off at any time.

I have the right to withdraw from the study at any time up till 30st May 2010 for personal interview only.

I understand that I can leave the focus group at any time but once given, the data cannot be withdrawn.

I understand that I will be offered a copy of the individual interview transcript and an opportunity to review it.

I understand that my participation in this study is confidential and that a third party who has signed a confidentiality agreement will transcribe the interviews.

I understand that transcripts of the interviews will be kept in a locked place and that that any information stored on computer files will be accessed by use of a password.

I understand that I can request an overview of the study once it is completed.

I understand that the information gathered from this study will be made available for public access.

**Title of study: A qualitative descriptive study exploring the experiences of mental health and addictions nurses who provide clinical supervision in a New Zealand District Health Board.**

I agree to take part in individual interviews.

I also agree/disagree to take part in a focus group (delete the inapplicable).

I..... (Full name) consent to take part in the above study.

Signature..... Date.....

Contact details.....

**Researcher:** Emilia Shupikayi Hlatywayo, Community Mental Health Nurse. [Removed]  
District Health Board. Ph. 07 834 6902 or 021 2230497. Email:hlatyway@yahoo.co.nz

**Supervisor:** Dr Kate Prebble, Senior Lecturer, School of Nursing, University of Auckland,  
PH. 09 3737599 Ext 83413. Email: k.prebble@auckland.ac.nz

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS  
ETHICS COMMITTEE ON 13/08/2009 for 3 years, Reference Number 2009/308.**

SCHOOL OF NURSING

Faculty of Medical and Health Sciences

Ecom House  
5<sup>th</sup> Floor 3 Ferncroft St  
Grafton  
Auckland  
Telephone 64 9 373 7599 Ext 87563  
Facsimile 64 9 367 7158

The University of Auckland  
Private Bag 92019  
Auckland Mail Centre 1142  
New Zealand

**Interview Guide**

**Title of study: A qualitative descriptive study exploring the experiences of mental health and addictions nurses who provide clinical supervision in a New Zealand District Health Board.**

Introductions, Purpose of study, Process, Confidentiality,

Collect demographic data: Gender, age, workplace, nursing experience (number of years), clinical supervision experience (number of years)

- 1- ***Topic to be explored:*** Factors that influence mental health nurses to take up the role of supervisor.

***Possible prompts:***

- Can you tell me about your nursing and /or mental health nursing background? (Probe around when training occurred, where, years of experience?)
- What motivates you to provide clinical supervision? ( explore intrinsic and extrinsic factors)

- 2- ***Topic to be explored:*** How clinical supervisors link previous CS experiences to current roles and expectations.

***Possible prompts:***

- How did you decide to be a clinical supervisor? Explore previous and current experiences in more detail. How did you carry out supervision then? And now? Are there any links?
- Can you tell me about the training you received for the role?



- How did you feel about the training?

3- ***Topic to be explored:*** How clinical supervisors deal with the various tensions arising during supervisory relationships.

Consider legal, social, political contexts and/or age, gender, sexuality, migrant status, ethnicity, religion, educational status, experience?

***Possible prompts***

- Power relations- What part does power play in your supervisor/supervisory relationship?
  - What issues if any are there for you in supervising colleagues?
  - How does power affect relationships with managers in relation to their supervisory roles?
- Can you tell me of a supervision session that went really well? And one that went badly?

4- ***Topic to be explored:*** How New Zealand legislation/regulations and DHB policies affect the practice of supervision.

***Possible prompts:***

- Tell me about any regulations, legislation or policies that impact on your role as a supervisor. How?

5 - ***Topic to be explored:*** Use of models and frameworks

- What models and frameworks do you use in supervision? What factors drive the use or non use of these models?
- What and who determines what happens with and during supervision?

6- ***Topic to be explored:*** Supervisor needs and how these are met or not met. Explore benefits and challenges

***Possible prompts***

- What are your feelings about your current role?
- What and who enables you to do your supervision well?
- How are you unable to do your role?
- Is there anything you would like to do differently?
- How do you propose to do this?

## **Appendix E**

SCHOOL OF NURSING

Faculty of Medical and Health Sciences

Ecom House  
5<sup>th</sup> Floor 3 Ferncroft St  
Grafton  
Auckland  
Telephone 64 9 373 7599 Ext 87563  
Facsimile 64 9 367 7158

The University of Auckland  
Private Bag 92019  
Auckland Mail Centre 1142  
New Zealand

### **CONFIDENTIALITY AGREEMENT FORM (for transcriber)**

**Study title: A qualitative descriptive study exploring the experiences of mental health nurses who provide clinical supervision in a New Zealand District Health Board**

**Name of Researcher: Emilia Shupikayi Hlatywayo. Community Mental Health Nurse. Waikato District Health Board, Ph. 07 834 6902. Email: hlatyway@yahoo.co.nz**

- I agree to transcribe interviews of this research.
- I agree not to disclose or discuss any information transcribed except to the researcher.
- I agree to keep all transcripts locked in a secure place.
- I agree to return all equipment and transcripts to the researcher at completion of transcribing.

Name.....

Signature.....

Date.....

**APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 13/08/2009, for 3 years, Reference Number 2009/308**

## REFERENCES

- Annells, M. (2007). What's common with qualitative nursing research these days? [Guest editorial]. *Journal of Clinical Nursing*, 16(2), 223-224.
- Arbon, P. (2004). Understanding experience in nursing. *Journal of Clinical Nursing*, 13(2), 150-157.
- Arvidsson, B., & Fridlund, B. (2005). Factors influencing nurse supervisor competence: A critical incident analysis study. *Journal of Nursing Management*, 13, 231-237.
- Arvidsson, B., Lofgren, H., & Fridlund, B. (2001). Psychiatric nurses' conceptions of how a group supervision programme in nursing care influences their professional competence: A 4 year follow-up study. *Journal of Nursing Management*, 9(3), 161-171.
- Barriball, L., While, A., & Munch, L. (2004). An audit of clinical supervision in primary care. *British Journal of Community Nursing*, 9(9), 389-397.
- Beck, C. T. (2001). Caring within nursing education: A meta-synthesis. *Journal of Nursing Education*, 3, 101-109.
- Beddoe, L. (2010). Surveillance or reflection: Professional supervision in 'the risk society'. *British Journal of Social Work*, 40(4), 1279-1296.
- Bedward, J., & Daniels, H. R. J. (2005). Collaborative solutions-Clinical supervision and teacher support teams: Reducing professional isolation through effective peer support. *Learning in Health & Social Care*, 4(2), 53-66.
- Begat, I., Berggren, I., Ellefsen, B., & Severinsson, E. (2003). Australian nurse supervisors' styles and their perceptions of ethical dilemmas within health care. *Journal of Nursing Management*, 11, 6-14.
- Begat, I., & Severinsson, E. (2006). Reflection on how clinical nursing supervision enhances nurses' experiences of well-being related to their psychosocial work environment. *Journal of Nursing Management*, 14(8), 610-616.
- Berg, A., & Hallberg, I. R. (1999). Effects of systematic clinical supervision on psychiatric nurses' sense of coherence, creativity, work-related strain, job satisfaction and view of the effects from clinical supervision: A pre-post test design. *Journal of Psychiatric & Mental Health Nursing*, 6(5), 371-381.
- Berggren, I., Barbosa da Silva, A., & Severinsson, E. (2005). Core ethical issues of clinical supervision. *Nursing & Health Sciences*, 7, 21-28.

- Berggren, I., & Severinsson, E. (2003). Nurse supervisors' actions in relation to their decision-making style and ethical approach to clinical supervision. *Journal of Advanced Nursing*, 41(6), 615-622.
- Bernard, J. M., & Goodyear, R. K. (1998). *Fundamentals of clinical supervision* (2nd ed.). Boston, MA: Allyn and Bacon.
- Bogdan, R. C., & Biklen, S. K. (1982). *Qualitative research for education: An introduction to theory and methods*. Boston, MA: Allyn and Bacon.
- Bond, M., & Holland, S. (1998a). *Skills of clinical supervision for nurses*. Buckingham, United Kingdom: Open University Press.
- Bond, M., & Holland, S. (1998b). *The surface picture: The development and value of clinical supervision*. Buckingham, United Kingdom: Open University Press.
- Bordin, E. S. (1983). Supervision in counselling: II. Contemporary models of supervision: A working alliance based model of supervision. *The Counselling Psychologist*, 11(1), 35-42.
- Bowles, N., & Young, C. (1999). An evaluative study of clinical supervision based on Proctor's three function interactive model. *Journal of Advanced Nursing*, 30(4), 958-964.
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.
- Bradshaw, T., Butterworth, A., & Mairs, H. (2007). Does structured clinical supervision during psychosocial intervention education enhance outcome for mental health nurses and the service users they work with? *Journal of Psychiatric & Mental Health Nursing*, 14(1), 4-12.
- Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing: An evidenced based literature review. *Australian Journal of Advanced Nursing*, 25(3), 86-94.
- Bulmer, C. (1997). Supervision: How it works. *Nursing Times*, 93, 53-54.
- Burns, N., & Grove, S. K. (2005). *The practice of nursing research: Conduct, critique and utilization*. St Louis, MO: Elsevier Saunders
- Burrow, S. (1995). Supervision: Clinical development or management control? *British Journal of Nursing* 4(15), 879-882.
- Butterworth, T. (1994). Preparing to take on clinical supervision. *Nursing Standard*, 8(52), 32-34.

- Butterworth, T., Bell, L., Jackson, C., & Pajnkihar, M. (2008). Wicked spell or magic bullet? A review of the clinical supervision literature 2001-2007. *Nurse Education Today*, 28(3), 264-272.
- Butterworth, T., Carson, J., White, E., Jeacock, J., Clements, A., & Bishop, V. (Eds.). (1997). *It is good to talk. An evaluation of clinical supervision and mentorship in England and Scotland*. Manchester, England: University of Manchester.
- Butterworth, T., & Faugier, J. (1992). *Clinical supervision and mentorship in nursing*. London, United Kingdom: Chapman and Hall.
- Butterworth, T., Faugier, J., & Burnard, P. (2001). *Clinical supervision and mentorship in nursing*. Cheltenham, United Kingdom: Nelson Thornes Limited.
- Buus, N., Angel, S., Traynor, M., & Gonge, H. (2010). Psychiatric hospital nursing staff's experiences of participating in group-based clinical supervision: An interview study. *Issues in Mental Health Nursing*, 31(10), 654-661. doi: 610.3109/01612840.01612010.01489991
- Buus, N., & Gonge, H. (2009). Empirical studies of clinical supervision in psychiatric nursing: A systematic literature review and methodological critique. *International Journal of Mental Health Nursing*, 18(4), 250-264. doi: 210.1111/j.1447-0349.2009.00612.x
- Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *Journal*, 2(2). Retrieved from <http://www.ualberta.ca/~iiqm/backissues/pdf/caellietal.pdf>
- Carolan, M. (2003). Reflexivity: A personal journey during data collection. *Nurse Researcher*, 13(3), 6-8.
- Carver, N., Ashmore, R., & Clibbens, N. (2007). Group clinical supervision in pre-registration nurse training: The views of mental health nursing students. *Nurse Education Today*, 27(7), 768-776.
- Chambers, M. (1998). Interpersonal mental health nursing: Research issues and challenges. *Journal of Psychiatric and Mental Health Nursing*, 5, 203-211.
- Cleary, M., & Freeman, A. (2005). The cultural realities of clinical supervision in an acute inpatient mental health setting. *Issues in Mental Health Nursing*, 26(5), 489-505.
- Cleary, M., Horsfall, J., & Happell, B. (2010). Establishing clinical supervision in acute mental health inpatient units: Acknowledging the challenges. *Issues in Mental Health Nursing*, 31(8), 525-531. doi: 510.3109/01612841003560546.

- Clibbens, N., Ashmore, R., & Carver, N. (2007). Clinical supervision. Group clinical supervision for mental health nursing students. *British Journal of Nursing* 16(10), 594-598.
- Clouder, L., & Sellars, J. (2004). Reflective practice and clinical supervision: An interprofessional perspective. *Journal of Advanced Nursing*, 46(3), 262-269.
- Consedine, M. (2001). Using role theory in clinical supervision. *Australian and New Zealand Psychodrama Association Journal*, 10, 37-49.
- Cooper, L., & Anglem, J. (2003). *Clinical supervision in mental health*. Adelaide, Australia: Flinders University.
- Cottrell, S. (2002). Suspicion, resistance, tokenism and mutiny: Problematic dynamics relevant to the implementation of clinical supervision in nursing. *Journal of Psychiatric and Mental Health Nursing*, 9(6), 667-671.
- Coyne, I. T. (1997). Sampling in qualitative research. Purposeful and theoretical sampling: Merging or clear boundaries. *Journal of Advanced Nursing*, 26, 623-630.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Crotty, M. (1996). *Phenomenology and nursing research*. Melbourne, Australia: Churchill Livingstone.
- Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Crows Nest, NSW, Australia: Allen & Unwin.
- Cummins, A. (2009). Clinical supervision: The way forward? A review of the literature. *Nurse Education in Practice*, 9, 215-220.
- Cutcliffe, J. (1997). Evaluating the success of clinical supervision. *British Journal of Nursing*, 6, 725-725.
- Cutcliffe, J. (2000). To record or not to record: Documentation in clinical supervision. *British Journal of Nursing* 9(6), 350-355.
- Cutcliffe, J. (2003). Clinical supervision and reflective practice: Symbient and integral aspects of the role of community psychiatric nurses. In B. Hannigan, M. Coffey & P. Burnard (Eds.), *A handbook of community mental health nursing*. London: Routledge.
- Cutcliffe, J., Butterworth, T., & Proctor, B. (2001). *Fundamental themes in clinical supervision*. London, United Kingdom: Routledge.
- Cutcliffe, J., & Goward, P. (2000). Mental health nurses and qualitative research methods: A mutual attraction? *Issues and Innovations in Nursing Practice*, 31(3), 590-598.

- Cutcliffe, J., & Hyrkas, K. (2006). Multidisciplinary attitudinal positions regarding clinical supervision: A cross-sectional study. *Journal of Nursing Management*, 14(8), 617-627.
- Cutcliffe, J., & Lowe, L. (2005). A Comparison of North American and European conceptualizations of clinical supervision. *Issues in Mental Health Nursing*, 26(5), 475-488. doi: 410.1080/01612840590931920.
- Cutcliffe, J., & Proctor, B. (1998). Clinical supervision. An alternative training approach to clinical supervision: 1. *British Journal of Nursing* 7(5), 280-285.
- Davey, B., Desousa, C., Robinson, S., & Murrells, T. (2006). The policy-practice divide: Who has clinical supervision in nursing? *Journal of Research in Nursing*, 11(3), 237-248.
- Davys, A. M., & Beddoe, L. (2008). Interprofessional learning for supervision: 'Taking the blinkers off'. *Learning in Health and Social Care*, 8(1), 58-69.
- Denzin, N. K., & Lincoln, Y. S. (1994). Entering the field of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1 -17). Thousand Oaks, CA: Sage.
- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage.
- Dickinson, T., & Wright, K. M. (2008). Stress and burnout in forensic mental health nursing: A literature review. *British Journal of Nursing* 17(2), 82-87.
- Dimond, B. (1998 a). Legal aspects of clinical supervision 1: Employer vs employee. *British Journal of Nursing*, 7(7), 393-395.
- Driscoll, J. (2007). *Practising clinical supervision: A reflective approach for healthcare professionals*. Edinburgh, N Y: Bailliere Tindall.
- Edwards, D., & Burnard, P. (2003). A systematic review of stress and stress management interventions for mental health nurses. *Journal of Advanced Nursing*, 42(2), 169-200.
- Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T.,...Coyle, D (2006). Clinical supervision and burnout: The influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing*, 15(8), 1007-1015.
- Edwards, D., Cooper, L., Burnard, P., Hannigan, B., Juggesur, T., Adams, J.,...Coyle, D (2005). Factors influencing the effectiveness of clinical supervision. *Journal of Psychiatric and Mental Health Nursing*, 12(4), 405-414.

- Elo, S., & Kyngas, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107-115.
- Eriksson, S., & Fagerberg, I. (2008). Supervisor experiences of supervising nursing staff in the care of older people. *Journal of Nursing Management*, 16, 876-882.
- Eruera, M. (2005). "He Korero Kokari". In L. Beddoe, L. Worrall & F. Howard (Eds.), *Weaving the strands of supervision: Proceedings of the supervision conference* (pp. 59 -65). Auckland, New Zealand: University of Auckland.
- Fain, J. A. (2004). *Reading, understanding, and applying nursing research* (2nd ed.). Philadelphia, PA: F.A. Davis Company.
- Falvey, J. E., & Cohen, C. R. (2003). The buck stops here: Documenting clinical supervision. *The Clinical Supervisor*, 22(2), 63-80.
- Farkas-Cameron, M. M. (1995). Clinical supervision in psychiatric nursing. *Journal of Psychosocial Nursing*, 33, 31-33.
- Farrington, A. (1995a). Defining and setting the parameters of clinical supervision. *British Journal of Nursing* 4(15), 874-875.
- Farrington, A. (1995b). Models of clinical supervision. *British Journal of Nursing*, 4, 876-878.
- Fenwick, J., Hauck, Y., & Downie, J. (2005). The childbirth expectations of a self selected cohort of Western Australian women. *Midwifery* 21, 23-35.
- Finfgeld-Connett, D. (2010). Generalizability and transferability of meta-synthesis research findings. *Journal of Advanced Nursing*, 66(2), 246-254.
- Fourie, W. J., McDonald, S., Connor, J., & Barlett, S. (2005). The role of the registered nurse in an acute mental health inpatient setting in New Zealand-Perceptions versus reality. *International Journal of Mental Health Nursing*, 14(2), 134-141.
- Fowler, J. (1995). Nurses perceptions of the elements of good supervision. *Nursing Times*, 91(22), 33-37.
- Geller, E., & Foley, G. M. (2009). Broadening the 'ports of entry' for speech-language pathologists: A relational and reflective model for clinical supervision. *American Journal of Speech-Language Pathology*, 18(1), 22-41.
- Gibbs, A. (1997). Focus groups. *Social Research Update*, 19, 1-4.
- Gilmor, J. A., & Huntington, A. D. (2005). Finding the balance: Living with memory loss. *International Journal of Nursing Practice*, 11, 118-124.



- Gilmore, A. (1999). *Review of the United Kingdom evaluative literature on clinical supervision in nursing and health visiting*. London, United Kingdom: United Kingdom Central Council for Nursing, Midwifery and Health Visiting.
- Gilmore, A. (2001). Clinical supervision in nursing and health visiting: A review of the United Kingdom literature. In J. Cutcliffe, T. Butterworth & B. Proctor (Eds.), *Fundamental themes in clinical supervision*. London, United Kingdom: Routledge.
- Giorgi, A. (1992). Description versus interpretation: Competing alternative strategies for qualitative research. *Journal of Phenomenological Psychology*, 23, 119-135.
- Gonge, H., & Buus, N. (2010). Individual and workplace factors that influence psychiatric nursing staff's participation in clinical supervision: A survey study and prospective longitudinal registration. *Issues in Mental Health Nursing*, 31(5), 345-354.
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24, 105-112.
- Grant, A., & Townend, M. (2007). Some emerging implications for clinical supervision in British mental health nursing. *Journal of Psychiatric & Mental Health Nursing*, 14(6), 609-614.
- Gray, W. (2001). Clinical governance: Combining clinical and management supervision. *Nursing Management*, 8(6), 14-22.
- Halloway, J., & Wheeler, S. (1996). *Qualitative research for nurses*. London, United Kingdom: Blackwell Science.
- Halpern, H., & McKimm, J. (2009). Clinical teaching made easy: Supervision. [Editorial review]. *British Journal of Hospital Medicine*, 70(4), 226-229.
- Hancox, K., Lynch, L., Happell, B., & Biondo, S. (2004). An evaluation of an educational program for clinical supervision. *International Journal of Mental Health Nursing*, 13(3), 198-203.
- Hawkins, P., & Shohet, R. (1989). *Supervision in the helping professions*. Milton Keynes, UK: University Press.
- Health Practitioners Competence Assurance Act. (2003).
- Herkt, J. A. (2005). *Exploring the supervision of occupational therapists in New Zealand*. Unpublished master's thesis, Auckland University of Technology, Auckland, New Zealand.

- Herkt, J. A., & Hocking, C. (2007). Supervision in New Zealand: Professional growth or maintaining competence? *New Zealand Journal of Occupational Therapy*, 54(2), 26-32.
- Heron, J. (1989). *Six- Category Intervention Analysis* (3rd ed.). Surrey, UK: Human Potential Resource Group, University of Surrey.
- Hines-Martin, V., & Robinson, K. (2006). Supervision as professional development for psychiatric mental health nurses. *Clinical Nurse Specialist: The Journal for Advanced Nursing Practice*, 20(6), 293-297.
- Howard, F., Burns, B., & Waitoki, W. (2007). Supervision in Aotearoa In I. M. Evans, J. J. Rucklidge & M. O'Driscoll (Eds.), *Professional Practice of Psychology in Aotearoa New Zealand*. Wellington, New Zealand: The New Zealand Psychological Society.
- Hyrkas, K. (2005). Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing*, 26(5), 531-556.
- Hyrkas, K., Appelqvist-Schmidlechner, K., & Haataja, R. (2006). Efficacy of clinical supervision: Influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing*, 55(4), 521-535.
- Hyrkas, K., Appelqvist-Schmidlechner, K., & Paunonen-Ilmonen, M. (2002). Expert supervisors' views of clinical supervision: A study of factors promoting and inhibiting the achievements of multiprofessional team supervision. *Journal of Advanced Nursing*, 38(4), 387-397.
- Hyrkas, K., Koivula, M., & Paunonen, M. (1999). Clinical supervision in nursing care in the 1990s - Current state of concepts, theory and research. *Nursing Management* 7, 177-187.
- Hyrkas, K., & Lehti, K. (2003). Continuous quality improvement through team supervision supported by continuous self-monitoring of work and systematic patient feedback. *Journal of Nursing Management*, 11(3), 177-188.
- Hyrkäs, K., Lehti, K., & Paunonen-Ilmonen, M. (2001). Cost-benefit analysis of team supervision: The development of an innovative model and its application as a case study in one Finnish University hospital. *Journal of Nursing Management*, 9(5), 259-268. doi: 210.1046/j.1365-2834.2001.00254.x.
- Hyrkas, K., & Paunonen- Ilmonen, M. (2001). The effects of clinical supervision on the quality of care: Examining the results of team supervision. *Journal of Advanced Nursing*, 33(4), 492-502.

- Johns, C. (1996). Visualizing and realising caring in practice through guided reflection. *Journal of Advanced Nursing*, 25, 1135-1143.
- Johnson, R., & Waterfield, J. (2004). Making words count: The value of qualitative research. *Physiotherapy Research International*, 9(3), 121-131.
- Jones, A. (1998). Getting going with clinical supervision: An introductory seminar. *Journal of Advanced Nursing*, 27(3), 560-566.
- Jones, A. (2003). Some benefits experienced by hospice nurses from group clinical supervision. *European Journal of Cancer Care*, 12(3), 224-232.
- Jones, A. (2006). Clinical supervision: What do we know and what do we need to know? A review and commentary. *Journal of Nursing Management*, 14(8), 577-585.
- Jubb Shanley, M., & Stevenson, C. (2006). Clinical supervision revisited. *Journal of Nursing Management*, 14(8), 586-592.
- Kavanagh, D. J., Spence, S., Sturk, H., Strong, J., Wilson, J., Worrall, L., et al. (2008). Outcomes of training in supervision: Randomised controlled trial. *Australian Psychologist*, 43(2), 96-104.
- Kelly, B., Long, A., & McKenna, H. (2001). A survey of community mental health nurses' perceptions of clinical supervision in Northern Ireland. *Journal of Psychiatric & Mental Health Nursing*, 8(1), 33-44.
- Kennedy, W. (2007). Professional supervision to enhance nursing practice. *Vision* (11749784), 14(2), 3-6.
- Kilcullen, N. (2007). An analysis of the experiences of clinical supervision on registered nurses undertaking MSc/graduate diploma in renal and urological nursing and on their clinical supervisors. *Journal of Clinical Nursing*, 16(6), 1029-1038.
- Kolb, D. A. (1984). *Experiential learning: Experience as a source of learning and development*. Engelwood Cliffs, NJ: Prentice Hall.
- Lakeman, R., & Glasgow, C. (2009). Introducing peer-group clinical supervision: An action research project. *International Journal of Mental Health Nursing*, 18(3), 204-210. doi: 210.1111/j.1447-0349.2009.00602.x.
- Landmark, B. T., Hansen, G. S., Bjones, I., & Bohler, A. (2003). Clinical supervision- Factors defined by nurses as influential upon the development of competence and skills in supervision. *Journal of Clinical Nursing*, 12(6), 834-841.

- Lennox, S., Skinner, J., & Foureur, M. (2008). Mentorship, preceptorship, and clinical supervision: Three key processes for supporting midwives. *New Zealand College of Midwives Journal*, 39, 7-12.
- Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry*, 3, 275-289.
- Lincoln, Y. S., & Denzin, N. K. (1994). The fifth moment. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 575 - 586). Thousand Oaks, CA: Sage.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- LoBiondo-Woods, G., & Haber, J. (2006). *Nursing Research: Methods and critical appraisal for evidence-based practice* (6th ed.). St Louis, MO: Mosby Inc.
- Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. *Counselling Psychologist*, 10, 3-42.
- Lynch, L., Happell, B., & Sharrock, J. (2008). Clinical supervision: An exploration of its origins and definitions. *Journal*, 13(2), 19p. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2009779715&site=ehost-live>
- Lynch, L., Happell, B., Sharrock, J., & Cross, W. (2008). Implementing clinical supervision for psychiatric nurses- The importance of education. *International Journal of Psychiatric Nursing Research*, 14(1), 1785-1796.
- Lyth, G. M. (2000). Clinical supervision: A concept analysis. *Journal of Advanced Nursing*, 31(3), 722-729.
- MacCulloch, T., & Shattell, M. (2009). Clinical supervision and the well-being of the psychiatric nurse. *Issues in Mental Health Nursing*, 30(9), 589-590.
- Majcher, J., & Daniluk, J. C. (2009). The process of becoming a supervisor for students in a doctoral supervision training course. *Training and Education in Professional Psychology*, 3(2), 63-71.
- Malin, N. A. (2000). Evaluating clinical supervision in community homes and teams serving adults with learning disabilities. *Journal of Advanced Nursing*, 31(3), 548-557.
- Marrow, C. E., Hollyoake, K., Hamer, D., & Kenrick, C. (2002). Clinical supervision using video- conferencing technology: A reflective account. *Journal of Nursing Management*, 10, 275-282.
- Maslach, c., & Jackson, S. (1986). *Maslach Burnout Inventory*. Palo Alto, CA: Consulting Psychologists.

- Mason, T. (2002). Forensic psychiatric nursing: A literature review and thematic analysis of role tensions. *Journal of Psychiatric & Mental Health Nursing*, 9(5), 511-520.
- McCabe, J. L., & Holmes, D. (2009). Reflexivity, critical qualitative research and emancipation: A Foucauldian perspective. *Journal of Advanced Nursing*, 65(7), 1518-1526.
- McKenna, B., Thom, K., Howard, F., & Williams, V. (2008). *Professional supervision for mental health and addiction nurses: A review of current approaches to professional supervision internationally and in the New Zealand mental health and addiction sector*. Auckland, New Zealand: Te Pou o Te Whakaaro Nui, the National Centre of Mental Health Research, Information and Workforce Development.
- McKinney, K. J. (2006). A Maori medical model of cultural supervision. *Maori and Pacific Island Health*, 33(5), 301-304.
- Mental Health Commission. (1998). *Blueprint for mental health services in New Zealand*. Wellington: Author.
- Mernick, J. E. (2009). *Creativity and life: The impact of clinical supervision on mental health nurses' relationships with consumers*. Unpublished master's thesis, University of Auckland, Auckland, New Zealand.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage.
- Mills, J. E., Francis, K. L., & Bonner, A. (2005). Mentoring, clinical supervision and preceptoring: Clarifying the conceptual definitions for Australian rural nurses. A review of the literature. *Rural & Remote Health*, 5(3), 1-10.
- Milne, D., & James, I. A. (2002). The observed impact of training on competence in clinical supervision. *British Journal of Clinical Psychology*, 41(Pt.1), 55-72.
- Milne, D., & Oliver, V. (2000). Flexible formats of clinical supervision: Description, evaluation and implementation. *Journal of Mental Health*, 9(3), 291-304.
- Milne, J., & Oberle, K. (2005). Enhancing rigor in qualitative description: A case study. *Journal of Wound Ostomy Continence Nursing*, 32, 413-420.
- Minichiello, V., Sullivan, G., Greenwood, K., & Axford, R. (Eds.). (2004). *Handbook of research methods for nursing and health science* (2nd ed.). Frenchs Forest, NSW, Australia: Prentice Hall.
- Ministry of Health. (2000). *The New Zealand health strategy*. Wellington, New Zealand: Author.

- Ministry of Health. (2002a). *Reducing inequalities in health*. Wellington, New Zealand: Author.
- Ministry of Health. (2002b). *Te Pauwaitanga Maori mental health national strategic framework*. Wellington, New Zealand: Author.
- Ministry of Health. (2004). *A health equity assessment tool (equity lens) for tackling inequalities in health*. Wellington, New Zealand: Public Health Consultancy, Wellington School of Medicine and Health Sciences.
- Ministry of Health. (2006). *Mental health nursing and its future: A discussion framework*. Wellington, New Zealand: Author.
- Ministry of Health. (2008). *Let's get real: Real skills for people working in mental health and addiction*. Wellington, New Zealand: Author.
- Mitchell, G. J. (2001). A qualitative study exploring how qualified mental health nurses deal with incidents that conflict with their accountability. *Journal of Psychiatric and Mental Health Nursing*, 8(241-248).
- Morgan, D. L. (1996). Focus groups. *Annual Review of Sociology*, 22, 129-152.
- Morrissey, J., & Tribe, R. (2001). Parallel process in supervision. *Counselling Psychology Quarterly*, 14(2), 103-110.
- Morse, J. M. (1991). Strategies for sampling. In J. M. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue* (pp. 127-145). Newbury Park, CA: Sage.
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods*, 1(2), 1-19.
- Morse, J. M., & Field, P. A. (1996). *Nursing Research: The application of qualitative approaches* (2nd ed.). London, United Kingdom: Chapman&Hall.
- Mullarkey, K., Keeley, P., & Playle, J. F. (2001). Multiprofessional clinical supervision: Challenges for mental health nurses. *Journal of Psychiatric & Mental Health Nursing*, 8(3), 205-211.
- Neergaard, M. A., Olesen, F., Andersen, R. S., & Sondergaard, J. (2009). Qualitative description-The poor cousin of health research? *Journal*, 9. doi:10.1186/1471-2288-9-52
- New Zealand Nurses Organisation. (2005). *Professional and clinical supervision* Wellington, New Zealand: Author.

- Nicklin, P. (1997). A practice-centred model of clinical supervision. *Nursing Times*, 93, 52-54.
- Nightingale, D. J., & Cromby, J. (Eds.). (1999). *Social constructionist psychology: A critical analysis of theory and practice*. Buckingham, United Kingdom: Open University Press.
- Nursing Council of New Zealand. (2005). *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice*. Wellington, New Zealand: Author.
- Nursing Council of New Zealand. (2007). *Competencies for registered nurse scope of practice*. Wellington, New Zealand: Author.
- Nursing Council of New Zealand. (2009). *Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice*. Wellington, New Zealand: Author.
- O'Donoghue, K. (1998). *Supervising social workers: A practical handbook*. Palmerston North, New Zealand: School of policy studies and Social Work, Massey University.
- O'Donoghue, K. (2000). *The future of social work supervision within Aotearoa/ New Zealand. From rhetoric to reality*. Paper presented at the National Supervision Conference Supervision Auckland College of Education, Auckland, New Zealand.
- Occupational Therapy Board of New Zealand. (2004a). *Code of ethics for occupational therapists*. Wellington: Author.
- Ogren, M. L. (2001). *Group supervision. Learning psychotherapy in a small group format*. Unpublished doctoral dissertation, Karolinska Institute, Stockholm, Sweden.
- Ovretveit, J. (1993). *Co-ordinating community care: Multidisciplinary teams and care management*. Buckingham, United Kingdom: Open University Press.
- Page, S., & Wosket, V. (2001). *Supervising the counsellor: A cyclical model* (2nd ed.). London, United Kingdom: Routledge.
- Papps, E., & Ramsden, I. (1996). Cultural safety in nursing: The New Zealand experience. *International Journal for Quality in Health Care*, 8(5), 491-497.
- Patton, M. Q. (2002). *Qualitative research and evaluative methods* (3rd ed.). Newbury Park, CA: Sage.
- Paulin, V. (2010). Professional supervision in dietetics: A focus group study investigating New Zealand dietitians' understanding and experience of professional supervision and their perception of its value in dietetic practice. *Nutrition & Dietetics*, 67(2), 106-111.

- Pearson, Q. M. (2001). A case in clinical supervision: A framework for putting theory into practice. *Journal of Mental Health Counselling*, 23(2), 174-183.
- Pesut, D. J., & Williams, C. A. (1990). The nature of clinical supervision in psychiatric nursing: A survey of clinical specialists. *Archives of Psychiatric Nursing*, 4(3), 188-194.
- Playle, J. F., & Mullarkey, K. (1998). Parallel process in clinical supervision: Enhancing learning and providing support. *Nurse Education Today*, 18(7), 558-566.
- Polit, D. F., & Beck, C. T. (2006). *Essentials of nursing research: Methods, appraisal and utilization* (6th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.
- Polit, D. F., & Hungler, B. P. (1999). *Nursing research. Principles and methods*. Philadelphia, PA: Lippincott.
- Pope, C., Ziebland, S., & Mays, N. (Eds.). (2000). *Qualitative research in health care: Analysing qualitative data* (2nd ed.). Oxford, United Kingdom: BMJ Books.
- Powers, S. (1999). *Nursing supervision: A guide for clinical practice*. London: Sage.
- Price, A. M., & Chalker, M. (2000). Our journey with clinical supervision in an intensive care unit. *Intensive and Critical Care Nursing*, 16, 51-55.
- Proctor, B. (1986). Supervision: A co-operative exercise in accountability. In M. Marken & M. Payne (Eds.), *Enabling and ensuring: Supervision in practice* (pp. 21-34). Leicester, United Kingdom: National Youth Bureau for Education and Community Work.
- Proctor, B. (1988). Supervision: A co-operative exercise in accountability. In M. Marken & M. Payne (Eds.), *Enabling and ensuring: Supervision in practice*. Leicester, United Kingdom: National Youth Bureau and Council for Education and Training in Youth and Community Work.
- Proctor, B. (2000). *Group supervision. A guide to creative practice*. Surrey, United Kingdom: Sage Publications, Biddles Limited.
- Proctor, B. (2001). Training for supervision alliance attitude, skills and intention. In J. Cutcliffe, T. Butterworth & B. Proctor (Eds.), *Fundamental themes in clinical supervision* (pp. 25-47). London, UK: Routledge.
- Proctor, B. (2010). Review: A randomised controlled trial of clinical supervision: Selected findings from a novel Australian attempt to establish the evidence base for causal relationships with quality of care and patient outcomes, as an informed contribution to



- mental health nursing practice development. *Journal of Research in Nursing*, 15(2), 169-172.
- Puanonen, M. (1991). Promoting nursing quality through clinical supervision. *Journal of Nursing Staff Development*, 229-233.
- Rains, E. (2007). Interdisciplinary supervisor development in a community health service. *Aotearoa New Zealand Social Work Review*, 19(3), 58-65.
- Ramsden, I. (1992). *Kawa whakaruruhau guidelines for nursing and midwifery education*. Wellington, New Zealand: Nursing Council of New Zealand.
- Rice, F., Cullen, P., McKenna, H., Kelly, B., Keeney, S., & Richey, R. (2007). Clinical supervision for mental health nurses in Northern Ireland: Formulating best practice guidelines. *Journal of Psychiatric & Mental Health Nursing*, 14(5), 516-521.
- Richards, D. A., Bee, P., Barkham, M., Gilbody, S. M., Cahill, J., & Glanville, J. (2006). The prevalence of nursing staff stress on adult acute psychiatric in-patient wards. *Social Psychiatry and Psychiatric Epidemiology*, 41(34- 43).
- Roberts, K., & Taylor, B. (2002). *Nursing research processes: An Australian perspective*. Victoria, Australia: Nelson.
- Robertson, G. (2000). *Disquiet in the development of clinical supervision for professional development in nursing practice: A literature review*. Unpublished master's thesis, Victoria University, Wellington, New Zealand.
- Rolfe, G. (2006). Validity, trustworthiness and rigour: Quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53(3), 304-310.
- Rounds, L. (2001). Clinical supervision: An American perspective. In J. R. Cutcliffe, T. Butterworth & B. Proctor (Eds.), *Fundamental themes in clinical supervision* (pp. 284- 302). London, UK: Routledge.
- Rydon, S. E. (2005). The attitudes, knowledge and skills needed in mental health nurses: The perspective of users of mental health users. *International Journal of Mental Health Nursing*, 14, 78-87.
- Saarikoski, M., Warne, T., Aunio, R., & Leino-Kilpi, H. (2006). Group supervision in facilitating learning and teaching in mental health clinical placements: a case example of one student group. *Issues in Mental Health Nursing*, 27(3), 273-285.
- Sandelowski, M. (2000). Focus on research methods: Whatever happened to qualitative description? *Research in Nursing and Health*, 23, 334-340.

- Sandelwoski, M. (1993). Rigor or rigor mortis: The problem rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.
- Sandelwoski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, 18, 179-183.
- Sandelwoski, M. (2004). Using qualitative research. *Qualitative Health Research*, 14(10), 1366-1386.
- Scanlon, C. (1998). Towards effective training of clinical supervisors. In V. Bishop (Ed.), *Clinical supervision in practice: some questions, answers and guidelines* (pp. 143-162). London: Macmillan.
- Scanlon, C., & Weir, W. S. (1997). Learning from practice? Mental health nurses' perceptions and experiences of clinical supervision. *Journal of Advanced Nursing*, 26(2), 295-303.
- Schamess, G. (2006). Therapeutic processes in clinical supervision. *Clinical Social Work Journal*, 34(4), 427-445.
- Schneider, Z., Whitehead, D., Elliott, D., LoBiondo-Woods, G., & Haber, J. (2007). *Nursing & midwifery research: Methods and appraisal for evidence-based practice* (3rd ed.). Sidney, Australia: Mosby Elsevier.
- Severinsson, E. (1996). Nurse supervisors' view of their supervisory styles in clinical supervision: A hermeneutical approach. *Journal of Nursing Management*, 4, 191-199.
- Severinsson, E. (2001). Confirmation, meaning and self-awareness as core concepts of nursing supervision model. *Nursing Ethics*, 8(1), 36-44.
- Severinsson, E., & Borgenhammer, E. (1997). Expert views on clinical supervision: A study based on interviews. *Journal of Nursing Management*, 5(3), 175-183.
- Severinsson, E., & Hallberg, I. R. (1996a). Clinical supervisors' views of their leadership role in the clinical supervision process within nursing care. *Journal of Advanced Nursing*, 24, 151-161.
- Severinsson, E., & Hallberg, I. R. (1996b). Systematic clinical supervision, working milieu and influence over duties: The psychiatric nurse's viewpoint- A pilot study. *International Journal of Nursing Studies*, 33(4), 394-406.
- Sheehan, A., Schmeid, V., & Cooke, M. (2003). Australian women`s stories of their breastfeeding decisions in pregnancy. *Midwifery*, 19, 259-266.
- Sloan, G. (1999). Good characteristics of a clinical supervisor: A community mental health nurse perspective. *Journal of Advanced Nursing*, 30(3), 713-722.

- Sloan, G. (2005). Clinical supervision: Beginning the supervisory relationship. *British Journal of Nursing* 14(17), 918-923.
- Sloan, G. (2008). Clinical supervision in mental health nursing: Accreditation anyone? *Mental Health Nursing*, 28(3), 18-20.
- Sloan, G., & Watson, H. (2001). John Heron's six-category intervention analysis: Towards understanding interpersonal relations and progressing the delivery of clinical supervision for mental health nursing in the United Kingdom. *Journal of Advanced Nursing*, 36(2), 206-214.
- Smythe, L., & Young, C. (2008). Professional supervision: Reflections on experience. *New Zealand College of Midwives Journal* 39, 13-15.
- Spence, C., Cantrell, J., Christie, I., & Samet, W. (2002). A collaborative approach to the implementation of clinical supervision. *Journal of Nursing Management*, 10(2), 65-74.
- Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision*, 39(7), 551-555.
- Sterner, W. R. (2009). Influence of the supervisory working alliance on supervisee work satisfaction and work-related stress. *Journal of Mental Health Counselling*, 31(3), 249-263.
- Stevenson, C. (2005). Postmodernising clinical supervision in nursing. *Issues in Mental Health Nursing*, 26(5), 519-529.
- Stoltenberg, C. D., McNeill, B., & Delworth, U. (1998). *IDM supervision: An integrated developmental model for supervising counsellors and supervisors*. San Francisco, CA: Jossey-Bass.
- Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.
- Streubert, H. J., & Carpenter, D. R. (1995). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia, PA: J. B. Lippincott.
- Sutcliffe, R. (2007). *What is the meaning of supervision for mental health support workers? A critical hermeneutic inquiry*. Unpublished master's thesis, AUT University, Auckland, New Zealand.
- Taylor, M., & Harrison, C. A. (2010). Introducing clinical supervision across Western Australian public mental health services. *International Journal of Mental Health Nursing*, 19(4), 287-293.

- Te Ao Maramatanga: New Zealand College of Mental Health Nursing. (2004). *Standards of practice for mental health nursing in New Zealand*. Auckland, New Zealand: New Zealand College of Mental Health Nursing Inc.
- Te Pou. (2009). *National guidelines for the professional supervision of mental health and addiction nurses*. Auckland, New Zealand: Te Pou, The National Centre of Mental Health Research, Information and Workforce Development.
- Te Pou. (2010). *Professional supervision training: An evaluation of a pilot study at Northland District Health Board*. Auckland, New Zealand: Te Pou, The National Centre of Health Research, Information and Workforce Development.
- Te Pou. (2011). *Professional supervision guide for nursing supervisors*. Auckland, New Zealand: Te Pou, The National Centre of Mental Health Research, Information and Workforce Development.
- Teasdale, K., Broklehurst, N., & Thom, N. (2001). Clinical supervision and support for nurses: An evaluation study. *Journal of Advanced Nursing*, 33(2), 216-224.
- Thompson, S., & Winter, R. (2004). A telephone led clinical supervision pilot for nurses in different settings. *Professional Nurse*, 18(8), 467-470.
- Thorne, S., Kirkham, S. R., & MacDonald-Emes, J. (1997). Focus on qualitative methods: Interpretive description: A non-categorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health*, 20, 166-177.
- Todd, G., & Freshwater, D. (1999). Clinical supervision. Reflective practice and guided discovery: Clinical supervision. *British Journal of Nursing* 8(20), 1383-1389.
- Townend, M. (2005). Interprofessional supervision from the perspectives of both mental health nurses and other professionals in the field of cognitive behavioural psychotherapy. *Journal of Psychiatric & Mental Health Nursing*, 12(5), 582-588.
- Townend, M. (2008). Clinical supervision in cognitive behavioural psychotherapy: Development of a model for mental health nursing through grounded theory. *Journal of Psychiatric & Mental Health Nursing*, 15(4), 328-339.
- Trochim, W., M, K. (2006). Research methods knowledge base: Qualitative validity (Publication. Retrieved from <http://www.socialresearchmethods.net/kb/qualval.php>
- Usher, K., Nolan, C., Reser, P., Owens, J., & Tollefson, J. (1999). An exploration of the preceptor role: Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. *Journal of Advanced Nursing*, 29, 506-514.

- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. London, Ontario: Althouse Press.
- Viney, T., Jukes, M., & Aldridge, J. (2006). Clinical supervision: The need for an integrative approach in supervising the experienced practitioner. In *Person-Centered Practices: A Therapeutic Perspective* (pp. 241-249). London, UK: Quay Books Mark Allen Group.
- Walker, J. (2009). Examining the benefits of professional clinical supervision [viewpoint]. *Kai Tiaki*, 15, 12.
- Walsh, K., Nicholson, J., Keough, C., Pridham, R., Kramer, M., & Jeffrey, J. (2003). Development of a group model of clinical supervision to meet the needs of a community mental health nursing team. *International Journal of Nursing Practice*, 9(1), 33-39.
- Waskett. (2010). Clinical supervision using the 4s model 1: Considering the structure and setting it up. *Nursing Times*, 106(16), 12- 14.
- Wepa, D. (Ed.). (2007). *Clinical Supervision in Aetearoa/ New Zealand*. Auckland, New Zealand: Pearson.
- White, E. (2010). FC03-05 - Quality of care and patient outcomes: A randomised trial of clinical supervision in mental health settings in Queensland, Australia. *European Psychiatry*, 25(3), 191.
- White, E., Butterworth, T., Bishop, V., Carson, J., Jeacock, J., & Clements, A. (1998). Clinical supervision: Insider reports of a private world. *Journal of Advanced Nursing*, 28(1), 185-192.
- White, E., & Roche, M. (2006). A selective review of mental health nursing in New South Wales, Australia, in relation to clinical supervision. *International Journal of Mental Health Nursing*, 15(3), 209-219.
- White, E., & Winstanley, J. (2006). Cost and resource implications of clinical supervision in nursing: An Australian perspective. *Journal of Nursing Management*, 14(8), 628-636.
- Whitehead, D., & Annells, M. (2007). Sampling data and data collection in qualitative research. In Z. Schneider, D. Whitehead & D. Elliott (Eds.), *Nursing and midwifery research: Methods and appraisal for evidence-based practice* (3rd ed., pp. 122-137). Sidney, Australia: Elsevier.
- Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in qualitative research. *Qualitative Health Research*, 11(4), 522-537.

- Wiley, A. (2009). At a cultural crossroads: Lesson on culture and policy from the New Zealand disability strategy. *Disability and Rehabilitation*, 31(14), 1205-1214.
- Wilson, J. (1999). Clinical supervision: Practicalities for the supervisor. *Accident and Emergency Nursing*, 7, 58-64.
- Winstanley, J. (2000). *Clinical Supervision: Development of an evaluation instrument*. Midwifery and Health Visiting, University of Manchester, Manchester, UK.
- Winstanley, J., & White, E. (2003). Clinical supervision: Models, measures and best practice. *Nurse Researcher*, 10(4), 7-38.
- Worthington, E. L., & Roehlke, H. J. (1979). Effective supervision as perceived by beginning counsellors in training. *Journal of Counselling Psychology*, 26(1), 64-73.
- Yegdich, T. (1999). Clinical supervision and managerial supervision: Some historical and conceptual considerations. *Journal of Advanced Nursing*, 30(5), 1195-1204.  
doi:1110.1046/j.1365-2648.1999.01189.x.
- Yegdich, T., & Cushing, A. (1998). An historical perspective on clinical supervision in nursing. *Australian & New Zealand Journal of Mental Health Nursing*, 7(1), 3-24.
- Zorga, S. (2002). Supervision: The process of life-long learning in social and educational professions. *Journal of Interprofessional Care*, 16(3), 265-276.