IMPLEMENTING CLINICAL SUPERVISION FOR PSYCHIATRIC NURSES – THE IMPORTANCE OF EDUCATION

By

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Abstract:

Increasing recognition of the potential value of clinical supervision for nurses has led to increased attention to introducing this initiative. However, a review of the literature suggests that the implementation of clinical supervision has occurred in the absence of clear guidelines or policy direction. Similarly, while the importance of education and training is acknowledged, the authors note the absence of clarity or consistency in documented implementation strategies. This paper focuses on Victoria, Australia, where the State Government provided significant funding to introduce clinical supervision throughout the State. The study setting is a mental health service in rural Victoria. In-depth interviews were held with senior nurses and members of the clinical supervision implementation committee (n=9). In relation to education and training, three main themes emerged: Identifying the need, making it happen, and being strategic. On the basis of this implementation experience, it is concluded that education and training is was a identified as an integral component of a structured implementation strategy.

Keywords: Clinical supervision, Education and training, Implementation, Psychiatric nursing

Introduction

The importance of clinical supervision as a means to address the stressful conditions associated with the nursing profession, and therefore enhance the recruitment of an adequate psychiatric nursing workforce has been widely acknowledged (Clifton, 2002; Hancox, Lynch, Happell & Biondo, 2004; McKeown & Thompson, 2001; Victorian Nurse Recruitment and Retention Committee, 2001).
In August 2000, the Department of Human Services Victoria, Australia, announced the release of considerable funding to support the introduction of clinical supervision for nurses (Hancox et al, 2004). The resourcing of this initiative primarily occurred through funding clinical nursing education teams throughout the State to implement a process to enhance supervision.

While the positions were welcomed, and have subsequently made significant inroads in introducing clinical supervision, this has occurred in the absence of a structured framework or specific guidelines to support the systematic implementation of this important and costly strategy. Consequently, most mental health services have grappled with this issue more or less in isolation from the knowledge and experience of others in the same situation. Anecdotal evidence suggests that many services have introduced innovative approaches to facilitate the introduction of clinical supervision, but frequently this has occurred in the absence of a strategic approach.

This lack of policy direction is not unique to Victoria. The literature provides many examples where the absence of guidelines has resulted in significant problems when implementing clinical supervision (Cutcliffe & Proctor, 1998; Clifton, 2002; Riordan, 2002; Fowler and Chavannes, 1998; Jones, 1998; Mullarkey & Playle, 2001).

A review of the nursing literature reveals a paucity of papers specifically focused on the implementation of clinical supervision. (Cutcliffe & Proctor, 1998; Clifton, 2002; Fowler and Chavannes, 1998; Gonsalvez, Oades & Freestone, 2002; Jones, 1998; Mullarkey & Playle, 2001; Riordan, 2002; Spence, Cantrell, Christie & Samet, 2002). Implementation has received more attention through text books than in the scholarly literature, with three main clinical supervision texts with chapters focused on implementation (Bond & Holland, 1998; Butterworth & Faugier, 1992; Driscoll, 2000).

Within the existing literature, the need for formalised education and training is recognised as an essential component for the successful implementation of clinical supervision. The importance of education and training has been attributed to two primary, but interrelated factors. Firstly, the culture of the nursing profession has not traditionally embodied clinical supervision as an essential part of professional practice. Secondly, education and training is required in order that both supervisors and supervisees have a clear understanding of clinical supervision, free from the many myths and misconceptions that frequently surface when this initiative is introduced. Education provided the opportunity for supervisors and supervisees alike to understand clinical supervision and be able to distinguish it from other relationships such as managerial supervision and therapy (McKeown, 2001; Riordan, 2002).

Specific training programs are described in the literature, however, considerable variation in the quality and quantity of these programs has been noted (Cutcliffe & Proctor, 1998; Clifton, 2002; Hancox et al, 2004; McKeown, 2001; White et al., 1998). Of even greater concern is that there has been a failure to examine education as an integral part of an overall strategy to support the implementation of clinical supervision.
Butterworth (1998) reported a considerable range in training courses available varying from one-hour professional development sessions, one or two-day workshops, to longer and more comprehensive courses, all with significant variations in content. The differences in courses available also meant that the countrywide implementation strategy was difficult to research and evaluate (Cutcliffe & Proctor, 1998; Butterworth, 1998).

A review of the literature attests to the importance of education as part of an overall strategy to support the introduction of clinical supervision. However, it is also evident that documented examples of the utilisation of education as an integral part of an implementation process are absent. The aim of this paper is to present the findings from a research study that demonstrates the importance of education for one mental health service as part of its process to implement clinical supervision for nurses.

Method

Design

A qualitative exploratory approach was selected. This methodology provides the researcher and the reader with a way of gaining insights through the discovery of meanings (Beanland, Schneider, LoBiondo- Wood & Haber, 1999; Burns & Grove, 1997). As the overall aim of this study was the analysis of an implementation strategy in an organisation “through the nurses’ eyes, through their subjective experiences” a qualitative research methodology was therefore appropriate to this study. The usefulness of qualitative methodology lies not only in the rich uniqueness of its findings but also in its ability for others to relate to this common experience (LoBiondo-Wood & Haber, 1990).

Setting

This research was conducted in a rural mental health service in South East Victoria, Australia. It was large mental health service providing a range of mental health services to over 3000 registered clients aged 0-65+. The service covered over 44,000sq kilometers and consisted of eight community centres and two inpatient units. Approximately 200 mental health clinicians were employed, 144 of which were nurses.

Sample

The team charged with the responsibility of implementing clinical supervision in this service were selected as the participants for this study. This sample consisted of nine nurses including the senior psychiatric nurse and psychiatric nurse consultant for the service. The other seven staff members had direct involvement with the implementation of clinical supervision and were the founding members of the clinical supervision implementation committee. Seven of the nine consented to participate in this research. The remaining two contacted the researcher to decline due to illness and work commitments.
Data Collection

As part of a larger study into the implementation of clinical supervision. Individual interviews were conducted with the members of the implementation committee. These interviews were conducted on site in the organisation and ranged from between 60 – 90 minutes in duration and the researcher used an in depth focused or semi structured interview technique, reflective of qualitatively orientated research (Minichiello, Aroni, Timewell & Alexander, 1996). This style of interviewing allowed the participants to describe their own experiences and express their own opinions about the clinical supervision implementation strategy.

Data analysis

The interviews were recorded and transcribed verbatim. The researchers then read the transcripts on a number of occasions searching for broad categories. The codes were then analysed in order to find commonalities, which led to the identification and articulation of the major themes. This process was conducted independently by two of the researchers to ensure rigour. The importance of education and training emerged as a major theme as part of the broader study examining the implementation of clinical supervision in a mental health service.

Ethical Issues

Ethics approval was gained from the Human Research and Ethics Committee at the Health Care Organisation and the University Scientific Committee. All participants received a copy of the Participant Information Sheet and Consent Form prior to participation. They were invited to contact the researcher via telephone if they had any questions or concerns. All participants were advised that involvement was voluntary and they were free to withdraw at any. All information relating to the collection and storage of data was in keeping with proper management of confidential research material.

Two major ethical issues were associated with this project. The first concerned confidentiality. The fact that this was a small rural organisation and members of the implementation committee were well known both within and externally to the service meant that while all efforts were taken, guaranteeing confidentiality was not possible. To minimise this problem, individual participants have not been identified by a pseudonym or participant number. Other characteristics such as gender or the position the participant held within the organisation has not been included.

The second related to the fact that the person conducting the interviews was one of the team providing the education and training on clinical supervision for the service. This led to concern that the participants may not have felt comfortable in expressing their true opinions about clinical supervision, particularly the training component. To overcome this, each participant was sent a letter giving them the opportunity to comment further on the training or any other issues they did not feel comfortable in discussing. It was arranged for this correspondence to be sent to a member of the research team with no allegiances to the training program or the auspice body. The participants were asked to respond to the letter, only if they felt the researchers’ presence inhibited what they wanted to say. Two participants chose to respond but
this was only to reinforce what a positive contribution the training program had made to the implementation of clinical supervision.

**Findings**

Data analysis revealed three main themes in relation to education and training:

1. Identifying the need
2. Making it happen, and

An overview of these themes will be presented and supported with quotes from the participants.

**Identifying the need**

The participants described the implementation process as developing somewhat informally. A team of senior managers, nurse educators and nurse consultants came together with the primary purpose of identifying strategies that might be used to assist with overcoming the low morale of the organisation. During this process they became aware of an educational program for clinical supervision being administered by the Centre for Psychiatric Nursing Research and Practice (CPNRP), Victoria, Australia. One participant described how this changed the focus of their thinking:

… what we had been trying to find for quite some time [was] how to support nurses in the clinical practice…[we] were all confronted with exactly the same problems and we were at our wits end about what to do… We had tried a range of things like education, clinical nurse educators on the unit, those sorts of things, but it wasn’t meeting our needs, and so when clinical supervision became available through the centre [CPNRP] we thought we would investigate that and look at how we could implement it

At this point the potential of clinical supervision to address some of the identified problems became the primary focus of the team.

The implementation team recognised that clinical supervision could not be introduced without a consistent and systematic approach. Part of this process would involve addressing some negative attitudes amongst nursing staff:

… people of course were suspicious that it was ‘snoopervision’, suspicious about having clinical supervision with someone who they actually knew, suspicious about having clinical supervision with people who they saw as their seniors, having clinical supervision with people they had not seen in clinical practice for a long time.

Ensuring that the implementation of clinical supervision was adequately supported by the organisation was therefore essential if staff were going to believe that it could be implemented and sustained. In addition, given the lack of knowledge and experience of clinical supervision within the organisation, support was also going to be needed to fund the training with the CPNRP for the nurses involved in implementation.
Financial support was essential and one participant described how she was able to be influential in this process:

… I sit in a very unique position. I am not blowing my own trumpet but I have got incredible credibility with senior management and so if I back a project it usually gets through… I had to write a business proposal to executive and say why we needed such a big financial commitment… they thought that if I believed that it would make a change to nurses then they would fund it, so…the way you get to that point in an organisation is just credibility.

The subsequent funding provided by the organisation was perceived positively as evidence that this time the organisation was committed to making sure this worked as described in the following example:

… the difference that I felt with this one [the clinical supervision initiative] is that you could see the financial commitment, but also the commitment for time for people to actually train.

Making it happen

The CPNRP was contracted by the organisation and the collaborating service to tailor an education and training package to their needs. This package consisted of the Clinical Supervision for Health Care Professionals course: a 36-hour course offered as an accredited subject and a series of One Day Workshops - Unlocking the Secret (Supervision for Supervisees). The initial course was tailored to be facilitated on site over four days and was delivered in September/October 2001. The participants in this initial course included those nurses chosen by the senior management team to lead its introduction. The findings identify that the links with the CPNRP and the education and training package that was offered was highly regarded:

…Because it was easily accessed … we were certainly aware of the need for networking, getting people out. This was… one of our opportunities to get back into the workforce in mental health, to hear about what's going on across the State… I knew that there was other clinical supervision training about but we didn't want to go anywhere else.

The decision to contract external providers to facilitate the training in clinical supervision provoked a range of responses from the leadership group and other nurses within the organisation. The participants discussed the advantages and disadvantages of contracting an external agency to do the training. The advantages they identified included:

Well, you're [the facilitators] not part of them – the "them" [management] and… people … see you [external facilitator] more as an expert or someone that actually had the credentials to be providing the education …I think they [nurses] value the information that's provided in those sessions more… I think people feel more relaxed to be honest about their fears and their concerns.
Furthermore:

… you get specialists; you get people who know their stuff and are expert in that area … people feel that they're valued when quality training is offered.

The absence of insider knowledge was viewed as a potential disadvantage, for example:

… [External facilitators] don't recognise the challenges we have got within our own organisation as far as geographical distances and the rural perspective of implementation…

One participant suggested a combination of internal and external facilitators:

I thought it was excellent that it [the training] was external. However … it would've been good to have an internal [facilitator] … There were issues coming out of some of the workshops early … and there were some issues that I believe probably could've been handled if someone from the organisation had been there. And that's nothing against the external facilitators, … It might've been something really simple like why is it [clinical supervision] mandatory? I find that they'd [nurses] ask questions that aren't huge questions, but unless you have knowledge of that specific area or that environment, then it's harder.

The participants in the first 4-day course stated clearly that it clarified for them what clinical supervision was, provided valuable information on the legal and ethical considerations, models and overall information on how to implement clinical supervision for the individual/organisation. As stated:

It gave a background to clinical supervision. Certainly the four day course gave a good outline of the supervisor's role… I believe when I did the training [it was] very beneficial. …I didn't know much about what was going on in clinical supervision so it was good to know some of the facts rather than the stories and paranoid fantasies that were running around.

The organisation also contracted the CPNRP to provide the 1-day introductory workshops for supervisees entitled- Clinical Supervision Unlocking the Secret. This training was seen as essential by many participants as evidenced by the following quote:

… people would go to those [one day workshops] and then actually take that information back and you'd notice that … people would come back and say – I went to that and it's not at all what we thought … so there was more positive talk. I think that really peppered through the whole project [and] really helped a lot.
Being Strategic

The four day course included a formal assessment component which consisted of an oral presentation and a 2,500 word assignment on clinical supervision. An alternative was negotiated where the participants of the first group had the option of completing a group project in the form of a strategic plan. The completed project-strategic plan contained the following: project overview, vision, values, mission, aims and objectives, background, current status, preparation, strategy, implementation in detail, models, evaluation (internal and external including forms), policies and protocols, clinical supervision agreements, record forms and references. The participants identified that the course and the assessment requirements was the catalyst for moving the initial implementation of clinical supervision forward as evidenced with the following findings:

…a lot of the groundwork was … undertaken within that four day training, the development of the policy, the protocol, and the implementation process, how we would look at implementation of clinical supervision, and all the groundwork that was being … discussed about how we would actually implement it, the issues, the challenges… the brick walls that you come across. We had lots of discussion over those four days.

Another participant felt the time pressure of having a due date for the project/strategic plan assisted to get things done more promptly and compared this with the experience of trying to write strategic plans in the workplace in the past:

… I don't think it [implementation of clinical supervision] would have happened as quickly…. It would have been one of those … ongoing things where you'd still be probably trying to launch it or something.

The strategic plan identified the need for education and training to be ongoing throughout the implementation process. Further training was contracted to ensure enough clinical supervisors available to provide supervision and thus enhance sustainability. The second group comprised mainly senior and program managers. This was a strategic decision to ensure the commitment to clinical supervision occurred at the highest level:

… two of our sector managers went off and did the clinical supervision course, and what doing the course has done for them is it has given them some insight and allowed – or given them some reasons to allow the staff to take time off…One of the [managers] has deliberately avoided the process the whole way along, but the uptake in [the] region is good so it is happening…I guess we did have some foresight in agreeing to and recognising that putting through the senior people first is really important if you are going to change the organisation.
There were other positive outcomes of managers attending the training and this is evidenced by the following findings:

I think the senior nurses and managers attending the training days in their own time was quite beneficial in showing that the organisation was committed to supporting clinical supervision...everyone knew the managers were going...word of mouth from the organisation is more effective than any education program.

Discussion

This paper reports a study that investigated the implementation of clinical supervision in a rural mental health service in Victoria, Australia. The issue of education and training emerged as a major theme during an exploration of the implementation of clinical supervision. Three main themes were revealed: Identifying the need; Making it happen; and, Being strategic.

After an informal start, the implementation committee of the mental health service recognised that clinical supervision could provide a mechanism for support for mental health nurses that would potentially lead to improved morale and other positive outcomes for the nurses within that service and this is consistent with the work of other authors (Clifton, 2002; Hancox, et al, 2004; McKeown & Thompson, 2001).

Identifying the need for clinical supervision led to the development of an overall strategy for its implementation in that service and part of that strategy was the application of an appropriate educational program. It has been noted previously that the literature overall is scant with regard to guidelines for implementing clinical supervision (Cutcliffe & Proctor, 1998; Clifton, 2002; Fowler and Chavannes, 1998; Gonsalvez, Oades & Freestone, 2002; Jones, 1998; Mullarkey & Playle, 2001; Riordan, 2002; Spence, Cantrell, Christie & Samet, 2002) and though some texts devote sections to it, this service decided that through education the strategy could commence, gain strength and become sustainable.

Making it happen, meant that organisational support for implementation and sustainability was crucial. The importance of organisational support was noted a dominant theme in the work of Driscoll (2000). The importance of financial support and allotted education time has been acknowledged in the literature (McKeown & Thompson 2001; Riordan, 2002). These resources are needed to provide the training required for nurses in the service given their lack of familiarity with clinical supervision. Furthermore funding for education and training enabled all levels of staff to access education and develop an organisational understanding of clinical supervision (McKeown, 2001; Riordan, 2002).
The findings support the observations of McKeown (2001) and Riordan (2002) that formalised training programs address the cultural aspects of implementing clinical supervision in nursing as well as providing the opportunity for full and frank discussion about its many dimensions. The extant literature reports an array of training programs but the application of these appears variable (Butterworth, 1998; Cutcliffe & Proctor, 1998; Clifton, 2002; Hancox et al, 2004; McKeown & Thompson, 2001; White et al., 1998). Consequently, a specific one was tailored for the service by the CPNRP. An initial four day introductory course was delivered followed by a series of one-day workshops for supervisees. The program was accessed easily by staff and was greatly respected.

The participants made it clear that trainers external to the organisation were seen to be impartial and to have more credibility and expert knowledge related to clinical supervision than trainers from within the service. However, it was noted by some participants that trainers from within the organisation working in partnership with an external trainer might allow for the contextualisation of the underlying concepts and principles. The existing literature does not articulate a preference for internal or external training or a combination. However, McKeown (2001) and Riordan (2002) emphasised the importance of education in clearly differentiating clinical supervision from other relationships including line management. The potential for these roles to become blurred may provide justification for the use of external trainers, either solely or in combination with an internal trainer.

Importantly, the place of education and training was seen as pivotal to the success of the implementation process. Education and training provided both supervisors and supervisees with a shared understanding of the concepts of clinical supervision as well as dispelling the myths surrounding it as suggested by McKeown (2001) and Riordan (2002).

Using the training program as a means to being strategic was also appreciated. Utilising the assessment requirements to develop a strategic plan further linked the training with the organisation and to the participants and ensured that implementation process was kept moving forward. The training program was comprehensive enough to address the salient aspects of clinical supervision but did not overburden participants with undue time commitments or “homework”.

It was seen that education needed to be ongoing to ensure that there were enough supervisors to meet the growing numbers of supervisees and senior organisational staff were included in the educational program to strengthen commitment and maintenance of clinical supervision within the service.

**Limitations of the Study**

This small (n=9) qualitative study focussed on a rural mental health service in Victoria, Australia. Whilst others may identify similar issues and outcomes in their own services, the results are not intended to be generalisable. Nevertheless the lessons from this study may assist others to develop an understanding of the place of education in the embedding of clinical supervision in mental health nursing services.
Conclusions

It appears from the results of this study that education and training linked strongly the implementation of clinical supervision. In particular, it offered the opportunity for participants to engage in the debates regarding clinical supervision; develop understanding of the constructs underpinning it; contextualise the principles; and acquire beginning skills. Significantly, it led to the development and sustainability of the implementation strategy itself.

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Thank you and keep up the good work, you are an inspiration to others.

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