This article will define and explore clinical supervision discussing briefly the theories why it is developing within nursing today and the barriers that are inhibiting its acceptance by community nurses. It will suggest that community nurses have previously had informal systems for supervision and support but within the current climate of the NHS these systems have been eradicated leaving nurses currently vulnerable and in urgent need of more formal mechanisms for supervision. It will highlight at macro and micro level what clinical supervision seeks to achieve and how this can benefit the nurse, patient and community unit. The role of the supervisor is defined and an example from clinical practice used to demonstrate the benefit of supervision.

Clinical supervision has been described as 'an exchange between practicing professionals to enable the development of professional skills'(Butterworth and Faugier 1992). It is a complex concept that has largely developed in an ad hoc way, its roots within social work, psycho-therapy, counselling and midwifery. More recently the concept is evolving within nursing although sadly many nurses are apprehensive about the development associating the term supervision with some type of inspection, criticism and discipline. There appears to be an assumption that this concept is a management led initiative designed to control rather than facilitate. Platt-Koch (1986) states that this confusion could be depriving nurses of one of the most valuable tools in existence for learning and refining skills of assessment and treatment of patients.

The publication of the document 'A vision for the future : the nursing, midwifery and health visiting contribution to health and health care' (DOH 1993) is perhaps one of the reasons why clinical supervision has been brought more sharply into focus. Target ten of this document stated that " discussions should be held at local and national level on the range and appropriateness of models of clinical supervision....." This statement coupled with flattening nursing management structures emerging within nursing today, mean that nurses will need to have identified support mechanisms in their working environments. Thus the necessity for fully operational clinical supervision systems to be in place becomes very apparent.

For community nurses the establishment of a well defined mechanism for clinical supervision should be welcomed and encouraged. The need for this has been reinforced by the document ' New World New Opportunities Working in Primary Health Care' (NHSME 1993). This document outlines 'keys to progress' for future working within primary health care, support being one of the main

'keys'. A later document 'Testing the Vision - a report of progress in the first year' (DOH 1994) stated that discussions on clinical supervision in nursing and health visiting had been held in 86% of nursing units. However from personal discussions with community nurses in varying areas of the UK and 'worried about clinical supervision' calls received to the Royal College of Nursing, it is clear that many community nurses are still vague about the concept of supervision. Further to this formal systems for supervision within many community units are still in their infancy or yet to be devised. This last statement is also supported by findings from the Health Visitors' Association (HVA Professional Briefing 1995).

At a macro level, clinical supervision is concerned with developing interprofessional support which reflects an active approach to promoting enhanced nursing practice. It could become the key to future professional nursing and, functioning properly, should allow practitioners to establish areas of need and the outcome of their work. This will in turn automatically feed into the commissioning process for community services. At a micro level clinical supervision is concerned with encouraging nurses to examine their practice so that weaknesses and mistakes are recognized and alternatives considered. Conversely strengths and successes will also be identified and this mechanism thus acts as a catalyst for the consolidation of knowledge and experiences which will hopefully lead to positive change and professional development. The need for all nurses to continually undertake professional development is reinforced by the implementation of Post Registration Education and Practice (UKCC 1995) and clinical supervision may well assist the nurse in identifying areas of development needed for optimum practice. An example to illustrate how this can take place is given by Cruickshank (1994). It could be said that community nurses have previously established their own informal systems for support, supervision and reflective practice, relying mainly on their peer group to facilitate this. However it may be that they had not perhaps recognized that this was an 'informal means of clinical supervision'.

This support was possible because community nurses were frequently based as part of a general community unit where they had regular contact with their peer group at meetings and over lunch breaks etc. Several factors however have severed this support : Since the implementation of the Community Care Act (1990) and the purchaser / provider model of health care, there has been a move towards General Practitioner (GP) fundholding with many district nurses working for, and based in, individual GP surgeries. This move has, in some cases, isolated nurses from their peer group. In the search for cost effectiveness within the NHS there is now a flattening of some management structures, which has effectively removed from nurses their previous management line of support

and advice. Some managers are now from non-nursing backgrounds and are responsible for nurses whose clinical activity falls outside their own clinical competency. Thus this compounds understanding of the complexity of the district nurses' role and may inhibit suitable supervision for that practitioner. Increasing workload in the community has also diminished nurse peer contact time at a crucial period when, in the current climate of change (with workload shift from secondary to primary care and more hi-tech community care) it is most needed. Community nurses have regularly voiced their concern that morale is low and recent research has demonstrated how unsupported district nurses feel (Ballard 1994). Yet nurses consistently avoid seeking support feeling they may be perceived as 'weak' or 'unable to cope'. Conversely some staff now simply do not know where to go for support because supervision structures are not yet in place.

It is obvious that nurses, whatever their speciality, now need to understand more about clinical supervision in order that this can be used effectively within their working environment. However whilst there is misinformation about supervision, practitioners will fail to utilise and value it. One study of clinical supervision by the Kings Fund Centre described the development of supervision in five different nursing development units. It was noted that in one unit, team members were ' strongly opposed' to use of the term seeing it as a threat to their autonomy as qualified practitioners (Kings Fund 1994).

Supervision has been an integral part of midwifery practice for many years (UKCC 1991) and although the general principle of supervision is that it is facilitative and empowering for practitioners it must be understood by those who use it. Midwifery supervision for example has not developed into one of empowering midwives, rather one of guidance and direction to ensure practice is correct. Clinical supervision has also been used as a disciplinary measure where practice was questionable, the case of Valerie Tomlinson a nurse who removed a patients appendix in Cornwall highlighted this. As part of the disciplinary action taken by her employers, Tomlinson faced " six months assessed clinical supervision" (Day 1995). Implying, in this case, that clinical supervision was a corrective action for incorrect practice. Any systems for clinical supervision should therefore avoid replicating these two examples.

Hallberg and Norberg (1993) suggest that ' clinical supervision' contributes to empowerment. The benefits incurred are not only seen in improving quality of care delivered but also relate to improved job satisfaction. Butterworth and Faugier (1992) say " it has a vital part to play in sustaining and developing professional practice " and several articles illustrate the concept of clinical supervision (Butterworth 1993, Jarvis 1992, Kaberry 1992, Hawkins and Shoet

1989 and Rolfe 1990) whilst a number of systems for supervision have been described by Houston (1990). Systems encountered in the community have involved supervision from within a team group setting or supervision either with an individual trained supervisor from the nurses peer group or a specifically trained supervisor (Byrne 1995). Currently reflective practice within a group setting was the most common source of supervision encountered when preparing this article. Supervision may be provided on a weekly basis or cover a wider time span but whoever facilitates supervision and whatever the time span there must be understanding of several factors :

Casement (1985) has described links between emerging theory of reflective practice and the need to develop a systematic approach to clinical supervision for practitioners. Therefore if supervision is to be successful community nurses must first have explored the theory of supervision as well as the needs of their specific area in terms of support and guidance. Participants must also see the benefit of the time required for supervision and give more freely to the supervision process as this develops. There are resource implications for clinical supervision and management must ensure time is given for it to take place effectively. There should also be trained supervisors available to undertake the role. Some supervisors may be identified from management whilst others identified by community nurses themselves. It is possible to have a supervisor from another clinical profession but the supervisee should feel comfortable with this. Nurses should have a key influence in determining who acts as their clinical supervisor (Fowler 1995). However would this be practicable in every area ? ".

One Community Trust has begun to use clinical supervision for its staff and has identified their Community Practice Teachers (CPT's) as supervisors to fully utilise them in an expanding role. This role could widen that of the CPT as the community unit needs change (RCN 1995), but whosoever acts as a supervisor will need to have adequate training and will need to be supported by their Trust so that they can fluently describe the resulting benefits of their role. This is especially important for the quality improvements in care that are achieved if they are to be offered to the purchasers of community nursing services.

Kadushin (1976) has described three roles for supervisors in clinical supervision. Firstly an educative role which involves developing abilities in practitioners through helping them understand experiences, develop awareness of interactions and dynamics and the consequences of their interventions. A useful example for learning from this would be for the supervisor to use critical incident analysis with the supervisee. Secondly, there is a supportive role which looks at the difficulties encountered by the practitioner relating to the emotions and

reactions of the supervisee. Lastly, there is a managerial role which provides a quality assurance element so that monitoring of optimum practice occurs. An example of how clinical supervision has been used in community practice is illustrated:

A community nurse had for some time visited a patient with multiple sclerosis. The patient was extremely difficult for both the nurse and her family to deal with. She was verbally aggressive and refused help to the extent that her family felt at the end of their tether. The nurse felt the patient and her family would cope with changes to her care programme such as day care and respite, however, the patient adamantly refused to even consider these ideas.. No amount of gentle persuasion could facilitate change. The nurse discussed the situation with her supervisor as the matter as causing her great distress. At this meeting the supervisor asked the nurse what she really wanted to do about the situation. The nurse said " I feel like shouting at Mrs. H and telling her what a fool she is and what a mess she is making both of her life and that of her family. I want to tell her she is driving me to the point of distraction and she is a pain in the neck to nurse".

When situations like this arise in the working environment nurses may experience undue distress which can lead to burnout (Nurse cited in Ballard 1994).

The supervisor in discussion with the nurse said she felt it may be helpful for the patient to know how the nurse really felt and that by clearing the air between them it could provide a constructive way of addressing the difficulties the nurse was experiencing. The nurse was given the confidence to use this approach with the patient and did so at the next visit.

In a heated discussion that followed between nurse and patient the patient confessed she used her awkward behaviour as a means of being in control of her carers. She realized she may be better with the care changes the nurse had suggested but she was frightened to change her routine in case her family liked the freedom of her going away and rejected her entirely. The nurse explained that she felt her carers tiredness was more likely to eventually alienate them from her and by allowing them some respite she would actually help their coping strategies.

The outburst did clear the air and the patient accepted the changes to her care. Eventually she completely changed her lifestyle and became much happier and a pleasure to nurse. The nurse stated she would not have felt able to have such a

conversation with the patient if she had not been supported in the decision to do it by her supervisor.

The purpose of these three roles of the supervisor outlined by Kadushin within clinical supervision is to incorporate the resolution of personal conflicts that arise from practice, reducing distress, emotional cacophony and feelings of isolation. Supervision can provide factual information which leads to change and development and the acknowledgment of responsibility and shared values thus ensuring an open communication system within a supportive climate where barriers and blocks are removed. The roles also support an outlook which differentiates personal needs from professional demands.

In summary from the literature review of clinical supervision it appears this may be a concept that is complex to operationalise within the community setting. However it will be achieved if clinical supervision is introduced to district nurses in a way that it is fully understood by them. In order to resolve misunderstanding about the concept there must be further work on the development of the theoretical underpinnings within practice and the suitability of the present definitions and models of supervision for the community nurses. Nurses will also need to be convinced that clinical supervision can be a constructive intervention for practice and formal systems to integrate this into the clinical environment will need to be identified. If this is not done nurses will remain unsupported and stressed and developments within practice stifled. The need for the training of designated supervisors will also have to be addressed within Trusts and purchasers will need to be convinced of the value and potential outcome of clinical supervision in improving the quality of patient care so that supervision is automatically written into purchasing contracts. The concept of clinical supervision is one of great value for future development of practice. We need to encourage community nurses to participate fully in clinical supervision and disseminate information about good practice so that this can contribute to the establishment of effective systems nationwide.

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